Supreme Court, U. S.
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EXHIBITS TO APPENDIX

IN THE

Supreme Court of the United States

OCTOBER TERM, 1975

No. 75-1691

Paul I. Guest, et al.,
Appellants,

v.

F. Emmett Fitzpatrick, Jr., et al.,
Appellees.

No. 75-1698

Williamsport Hospital, et al.,
Appellants,

v.

F. Emmett Fitzpatrick, Jr., et al.,
Appellees.

Appeals from the United States District Court for the Eastern District of Pennsylvania

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No. 75-1691, Filed May 21, 1976
No. 75-1698, Filed May 24, 1976
Probable Jurisdiction Noted October 4, 1976

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Exhibit A

A. EXHIBITS TO AFFIDAVITS OF APPELLANTS

COMMONWEALTH OF PENNSYLVANIA }
COUNTY OF PHILADELPHIA } *ss:*

FRED G. CLARK, being duly sworn according to law, deposes and says the following based on his personal knowledge thereof:

1. That he is the Vice President of Finance of Epsicopal Hospital, a non-profit corporation organized under the laws of Pennsylvania and located at Front Street and Lehigh Avenue, Philadelphia, Pennsylvania 19125.

2. That in this capacity, and previously as Comptroller, he is responsible for maintaining the fiscal viability of Episcopal Hospital and has responsibility for recommending to the President for transmittal to the Board of Trustees a schedule of patient charges in accordance with this purpose; he has discharged these duties for two and a half years.

3. That he has read the Affidavit of Edward J. Armstrong in support of the Motion for Summary Judgment by Plaintiffs and Plaintiffs Intervenors and agrees with and incorporates herein the facts stated in that Affidavit insofar as they describe the general principles of sound fiscal policy which a hospital must adhere to and the manner in which the provisions of the Delaware Valley Agreement affect fiscal policy.

4. That specifically Blue Cross refuses to recognize in its reimbursement under the Delaware Valley Agreement the Hospital's expense in providing free care and in covering losses due to bad debts other than those of Blue Cross subscribers; that the Blue Cross reimburse-

Exhibit A

ment formula does not permit a hospital to meet its current operating needs; and further, that the reimbursement formula fails to make adequate provision for the expansion, replacement or improvement of the Hospital's plant and equipment in the form of an "operating growth needs factor" as detailed in paragraphs 11-14 of Mr. Armstrong's Affidavit.

5. That Episcopal Hospital's financial statement for the fiscal year ending June 30, 1975, prepared by Coopers and Lybrand, shows an operating loss of $1,296,301. (This financial statement is attached hereto at Attachment "A".)

6. That in fiscal year 1975 Episcopal's net unreimbursed charges for patient care amounted to $1,480,402 which includes $583,582 for free care, $1,067,105 for bad debts, less $170,285 in payments from the City of Philadelphia towards outpatient and emergency room services.

7. That the amount of unreimbursed patient care which ought to be reimbursed by Blue Cross in proportion to the percentage of inpatient charges for services rendered Blue Cross subscribers (22.78%), but which Blue Cross will not reimburse under the Delaware Valley Agreement, is $337,235.

8. That it would be plainly impossible for the 11.37% of Episcopal Hospital's paying patients who are either self-insured or insured by private insurance companies to pay increased charges sufficient to absorb losses suffered by the Hospital as a result of unreimbursed patient care.

9. That in order to offset the operating loss of $1,296,301 for fiscal year 1975, Episcopal Hospital applied the full amount of interest earned by its endowment fund or $474,721 plus additional non-operating income from other sources to produce a net loss for that year of $635,217. The corresponding net loss figure for fiscal year 1974 was $573,811 and for fiscal year 1973, $646,388.

Exhibit A

10. That under Pennsylvania law (Section 7550 of the Pennsylvania Non-profit Corporation Law of 1972, 15 Pa. C.S. § 7550), a non-profit corporation may transfer from the accumulated net gains of its endowment funds an amount up to a maximum of nine (9%) per cent per year of market value less income received. Episcopal Hospital took full advantage of this provision in fiscal year 1975 to transfer $231,050 from its endowment principal. In fiscal year 1974, it transferred $437,375, and the Board of the Hospital has voted to transfer $273,792 in fiscal year 1976 to meet the Hospital's operating expenses. Thus, in three years, Episcopal Hospital will have been required to reduce its endowment fund principal by close to $1,000,000.

11. That for fiscal year 1975 the depreciation reserve for Episcopal Hospital was $633,298. In order to show a break-even figure for that year, it would be necessary to apply $404,167 or nearly two-thirds of the depreciation fund towards the net loss figure of $635,217 as reduced by the $231,050 taken from endowment fund principal. Alternatively, Episcopal could have avoided cutting into its endowment principal and instead applied virtually all of its depreciation funding to offset its net losses for fiscal year 1975.

12. That in order to meet its normal operating expense, Episcopal Hospital has been forced for the past two years to apply its total endowment fund income, to reduce its endowment fund principal to the extent permitted by law, and to deplete its depreciation reserve by nearly two-thirds to offset a net operating loss, a pro rata share of which ought to be reimbursed by Blue Cross subscribers in common with all other paying patients, but is not recoverable from Blue Cross under the principles of reimbursement in the Delaware Valley Agreement.

Exhibit A

The foregoing is true and correct to the best of my personal knowledge.

/s/Fred G. Clark

Fred G. Clark

(Oath and Jurat Omitted in Printing)

Exhibit B

Commonwealth of Pennsylvania }
County of Philadelphia } *ss:*

Ragnar W. Anderson, being duly sworn according to law, deposes and says the following based on his personal knowledge thereof:

1. That he is the Acting Director of Fiscal Affairs and Controller of Mercy Catholic Medical Center, Fitzgerald Mercy Division ("MCMC"), a non-profit corporation organized under the laws of Pennsylvania and located at Lansdowne Avenue and Baily Road, Darby, Pennsylvania, 19023.

2. That he is responsible for maintaining the fiscal viability of MCMC and has authority for recommending to management and the Board of Trustees a schedule of patient charges in accordance with this purpose; he has discharged these duties at MCMC for three years.

3. That he has read the Affidavit of Edward J. Armstrong in support of the Motion for Summary Judgment by Plaintiffs and Plaintiffs Intervenors and agrees with and incorporates herein the facts stated in that Affidavit insofar as they describe the general principles of sound fiscal policy which a hospital must adhere to and the manner in which the provisions of the Delaware Valley Agreement affect fiscal policy.

4. That specifically Blue Cross refuses to recognize in its reimbursement under the Delaware Valley Agreement the Hospital's expense in providing free care and in covering losses due to bad debts other than those of Blue Cross subscribers; that the Blue Cross reimbursement formula does not permit a hospital to meet its current operating needs, and further, that the reimburse-

ment formula fails to make adequate provision for the expansion, replacement or improvement of the Hospital's plant and equipment in the form of an "operating growth needs factor" as detailed in paragraphs 11-14 of Mr. Armstrong's Affidavit.

5. That for fiscal year 1974, the total cost to MCMC of unreimbursed patient care including free care and bad debts was $3,043,544, as shown on the Hospital's certified financial statement attached hereto at Attachment "A."

6. That if Blue Cross paid MCMC their share of these costs in the same proportion which Blue Cross covered charges bear to total charges entered by the Hospital against its patients, Blue Cross would have paid MCMC an additional $655,624 (represented by $851,938 in charges), for fiscal year 1974. Blue Cross would pay no part of these costs under the Delaware Valley Agreement.

7. That in order partially to reduce its losses resulting from unreimbursed patient care, MCMC is required to surcharge its private paying patients. Thus, whereas Blue Cross reimbursement for an eight-day hospital stay during fiscal year 1974 would have been $856, commercial insurance companies paid MCMC an average of $1,238, or 44% more than the amount payable by Blue Cross. Among other commercial insurers which reimburse MCMC full charges without even a patient co-payment requirement are Aetna, Prudential and Metropolitan.

8. That, in addition to the fact that Blue Cross does not reimburse MCMC full charges under the Delaware Valley Agreement, even such payments as it does make are not available for current operating expenses. This is because the contract provision for working capital advances presupposes a 15-day cycle from the time of billing to the time of payment while, in fact, the experience at MCMC has been that this delay in payment averages

42 days. Thus, at any given time, MCMC has about half a million dollars more in unreimbursed costs due from Blue Cross than contemplated by the 15-day working capital advance program.

9. That both on a short and long-term basis, MCMC is forced to use virtually all of the money that would otherwise have been funded from depreciation in order to meet its operating expenses and accordingly, is required to borrow money for capital improvements.

10. That MCMC has virtually no endowment fund income from which to make up operating costs not reimbursed by third party payors like Blue Cross.

The foregoing is true and correct to the best of my personal knowledge.

/s/ RAGNAR W. ANDERSON

Ragnar W. Anderson

(Oath and Jurat Omitted in Printing)

Exhibit C

COMMONWEALTH OF PENNSYLVANIA }
COUNTY OF PHILADELPHIA } *ss:*

CARL L. MOSHER, being duly sworn according to law, deposes and says the following based on his personal knowledge thereof:

1. That he is the President of Presbyterian-University of Pennsylvania Medical Center ("PUPMC"), a non-profit corporation organized under the laws of Pennsylvania and located at 51 North 39th Street, Philadelphia, Pennsylvania 19104.

2. That he is responsible for maintaining the fiscal viability of PUPMC and has final authority for recommending to the Board of Trustees a schedule of patient charges in accordance with this purpose.

3. That he has read the Affidavit of Edward J. Armstrong in support of the Motion for Summary Judgment by Plaintiffs and Plaintiffs Intervenors and while he is not familiar with matters relating specifically to Jeanes Hospital, agrees with and incorporates herein the general principles stated in that Affidavit insofar as they describe the general basis of sound fiscal policy which hospitals must adhere to and the manner in which the provisions of the Delaware Valley Agreement affect fiscal policy.

4. That specifically Blue Cross refuses to recognize in its reimbursement under the Delaware Valley Agreement the Hospital's expense in providing free care and in covering losses due to bad debts other than those of Blue Cross subscribers; that the Blue Cross reimbursement formula does not permit a hospital to meet its full current operating needs; and further, that the reimbursement formula fails to make adequate provision for the

Exhibit C

expansion, replacement or improvement of the Hospital's plant and equipment in the form of an "operating growth needs factor" as illustrated in the example detailed in paragraphs 11-14 of Mr. Armstrong's Affidavit.

5. That for the fiscal year 1974, PUPMC provided free care, exclusive of bad debts, amounting to an unrecovered cost to the Hospital of $847,500.00, or 5% of the Hospital's total reimbursable costs.

6. That, since Blue Cross patients represent approximately 24% of total patient billings, and following standard Medicare principles of reimbursement in allocating costs on the basis of charges, the pro rata share of the unrecovered cost of free care which ought to have been paid by Blue Cross in fiscal year 1974 was at least $203,400. Under the principles of reimbursement in the Delaware Valley Agreement, Blue Cross refuses to pay any portion of this amount.

7. That as a result in large part of losses due to unreimbursed patient care (paragraph 6), PUPMC showed an operating loss for fiscal year 1974 of $1,774,000, per Coopers and Lybrand Certified Audit Reporting. After applying against this operating loss $985,000 of income from unrestricted contributions, PUPMC showed a bottom line net loss of $789,000 for fiscal year 1974. (A copy of the certified financial statement for PUPMC for fiscal year 1974 is attached hereto at Attachment "A".)

8. That not only does Blue Cross pay PUPMC less than its pro rata share of the Hospital's total cost of operation, but frequently what it has paid, has been paid only after considerable delay and, at no time, has PUPMC been paid interest for the period of time when money already earned by PUPMC continued to earn interest for Blue Cross.

Exhibit C

9. That the following examples of delay suffered by PUPMC in receiving payments from Blue Cross put in perspective the latter's provision of an advance equal to 15 days of current costs and offer of an additional 15-day advance upon which, if utilized, the Hospital must pay interest (see Supplemental Affidavit of Bruce Taylor at paragraphs 70-71):

(a) During 1970 and 1971, Blue Cross challenged PUPMC allowable costs and refused to pay any part of the challenged costs of $541,911 for the fiscal year ending June 30, 1970, until on January 3, 1973, the Hospital settled for $330,000 or 61 per cent of the disputed costs which it had expended more than two years earlier. It was only after the Hospital had agreed to settle for less than cost reimbursement that the Hospital also received payment of $478,247 held back for the fiscal year 1971. Thus, Blue Cross held back almost $1,000,000, some of this for more than two years. The Hospital never received any interest on that money.

(b) On September 22, 1975, the Hospital filed with Blue Cross its Blue Cross cost report for the fiscal year ended June 30, 1975. That cost report reflects a substantial sum of unreimbursed money owing to the Hospital for the prior fiscal year. As of the date of this writing, the Hospital has received no response from Blue Cross. It is the Hospital's understanding that its fiscal 1975 cost report was one of the first four or five cost reports received by Blue Cross.

(c) Subsequent to the enactment of Act 94 and pursuant to the understanding that the parties would proceed in accordance with the provisions of that Act, the Hospital responded to a request by Blue Cross and on September 10, 1975, submitted its operating

Exhibit C

budget for fiscal year 1976. The main purpose of this budget submission was to provide Blue Cross with financial data to revise and adjust interim per diem reimbursement rates. As of the date of this writing, the Hospital has received no increase in interim per diem rate from Blue Cross.

10. That, at least in part as a result of the inadequacy of Blue Cross reimbursement and the delay in receipt of Blue Cross payments, PUPMC has insufficient working capital requiring the Hospital, in many cases, to borrow money at high interest rates simply to meet its operating expenses.

The foregoing is true and correct to the best of my personal knowledge.

/s/ CARL L. MOSHER

Carl L. Mosher

(Oath and Jurat Omitted in Printing)

Exhibit 1

B. EXHIBITS TO AFFADAVITS OF APPELLEES

AMENDED AND RESTATED
ARTICLES OF INCORPORATION
OF
BLUE CROSS OF GREATER PHILADELPHIA

ARTICLE I. The name of the corporation is:

BLUE CROSS OF GREATER PHILADELPHIA

ARTICLE II. The address of its registered office in this Commonwealth is:

1333 Chestnut Street
Philadelphia, Pennsylvania 19107

ARTICLE III. The corporation does not contemplate pecuniary gain or profit, incidental or otherwise. The purposes for which it is formed are:

1. To establish, maintain and operate a non-profit plan whereby hospitalization and health benefits may be provided to subscribers to such plan.

2. To make and enter into contracts with duly licensed hospitals, extended care facilities, nursing homes, convalescent homes and other organizations to provide any of the services to subscribers to such plan for which benefits or coverages are contemplated pursuant to paragraph 3 hereof.

3. To establish a plan providing (a) certain hospital services to be rendered by such hospitals to subscribers, (b) indemnities for certain medical services only when incident to hospitalization in duly licensed hospitals, to wit: laboratory, electro-cardiographic and x-ray examinations, metabolism tests, anesthesia and physical therapy, to be

Exhibit 1

rendered by physicians to subcribers in accordance with the arrangements then existing between the hospitals and the physicians rendering such services, and (c) any or all of the following benefits or coverages, except that the corporation shall not pay for any doctors' professional services to patients in connection with any of the following benefits or coverages:

(1) extended benefits or major medical coverage indemnifying subscribers for certain expenses in excess of the benefits included in the basic coverage,

(2) benefits in extended care facilities and nursing or convalescent homes,

(3) nursing care, including visiting nurse service,

(4) home care, consisting of an organized program of health services provided under the direction of a physician to a patient at home,

(5) drugs, medicines and medical supplies and appliances for use outside of a hospital,

(6) any and all other health or related services, including without being limited to, hearing and vision care, and multiphasic screenings.

4. To issue subscription agreements to subscribers to the said non-profit plan and to enter into group contracts in accordance with these purposes.

5. To act as an agency or organization under Section 1816 of Title XVIII of the Federal Social Security Act, known as "Medicare," 42 U.S.C.A. Section 1395h, and its amendments, with power to perform all the services which may be required of an agency or organization thereunder; to perform services, similar or related to those which may be required of an agency or organization as aforesaid, in connection with any federal, state or local governmental

health care program; to perform services, similar or related to those which may be required of an agency or organization as aforesaid in connection with or associated with non-governmental organizations, individuals, groups and agencies in the health care field.

6. To do everything and anything necessary, suitable, proper, convenient and incidental to the aforesaid purposes, or which may be done by a corporation organized for such purposes under the laws of the Commonwealth of Pennsylvania, together with all the powers now or which may hereafter be permitted to it by the laws of the Commonwealth of Pennsylvania.

ARTICLE IV. The corporation shall exist perpetually.

ARTICLE V. The corporation is organized on a non-stock basis.

ARTICLE VI. The corporation shall have no members.

ARTICLE VII. (a) The business and affairs of the corporation shall be managed by a board of at least 25 directors. All of the directors of the corporation (except not to exceed five ex-officio directors selected as may be provided in the by-laws and except directors selected for such terms as may be provided in the by-laws to fill vacancies) shall be elected by the Subscribers to the non-profit plan established, maintained and operated by the corporation (herein referred to as the "Subscribers") or their proxies in such manner and for such terms as may be provided in the by-laws. All directors of the corporation shall be Subscribers residing within the area served by the corporation. The by-laws may provide fair and reasonable procedures for the nomination of candidates for the office of director, but such by-laws shall always

permit 300 or more Subscribers to place any eligible person in nomination for the office of director in the manner provided in such by-laws.

(b) At any special meeting of the Subscribers called for the purpose in the manner prescribed in the by-laws by 10% of the Subscribers entitled to vote at an election of directors, the entire board of directors, or any individual director may be removed from office without assigning any cause, by a majority vote of Subscribers present in person or by proxy and voting at such meeting. In case the Board or any one or more directors is so removed, new directors may be elected at the same meeting.

ARTICLE VIII. (a) Any of the following plans or other corporate action may be proposed by petition of 10% of the Subscribers entitled to vote at an election of directors, which petition shall be directed to the board of directors and filed with the Secretary of the corporation:

(1) The amendment of the articles or the adoption, amendment and repeal of the by-laws.

(2) A plan of sale, lease or exchange of assets under 15 Pa. S. § 7930.

(3) A plan of merger, consolidation, division or conversion.

(4) The voluntary dissolution of the corporation.

(b) Except as provided in Paragraph (c) of this Article, any plan or other corporate action specified in Paragraph (a) of this Article, after having been proposed either by the board of directors or by petition of Subscribers, shall be submitted to a meeting of Subscribers (to be held not more than 60 days after the receipt of a petition, in the case of a meeting of Subscribers to consider and take action on any matter pro-

posed by petition under Paragraph (a) of this Article), and shall be deemed adopted by the corporation when, and only when, approved by the affirmative vote of a majority of Subscribers present in person or by proxy and voting at any regular or special meeting of Subscribers called and held as may be provided in the by-laws, and approved in writing by the Insurance Commissioner and the Governor of the Commonwealth of Pennsylvania.

(c) Unless otherwise restricted in a by-law adopted by the Subscribers after September 1, 1973, the board of directors shall have the full authority vested by law in the board of directors of a corporation without members to adopt, amend and repeal the by-laws of the corporation.

BY-LAWS
OF
BLUE CROSS OF GREATER PHILADELPHIA

ARTICLE I

Subscribers

Section 1.01. *Definition.* For the purposes of these By-Laws and Articles VII and VIII of the Articles of Incorporation of this Corporation, the term "Subscriber" shall mean any individual 18 years of age or over who:

(1) has a subscription agreement in force in his name or a group identification card bearing his name issued by or on behalf of the Corporation; or

(2) is entitled to benefits under a group contract with the Corporation which provides coverage for all such persons in that group without specifying individual names; or

(3) is entitled to benefits as an eligible dependent of a person described in subsections (1) or (2) of this Section.

Section 1.02. *Classes.* All Subscribers shall constitute a single class for the purposes of voting by class pursuant to any statutory provision requiring a vote by class for any purpose.

ARTICLE II

Meetings of Subscribers

Section 2.01. *Place of Meeting.* All meetings of the Subscribers shall be held at such place within the City

of Philadelphia as is designated in the notice of such meeting by the person authorized by these By-Laws to give such notice.

SECTION 2.02. *Annual Meeting.* The Annual Meeting of the Subscribers shall be held on the fourth Tuesday of February, if not a legal holiday under the laws of Pennsylvania, otherwise on the next succeeding business day not a Saturday, at 6:00 P.M. or such other hour as may be designated in the notice of the meeting. At said meeting the Subscribers then entitled to vote shall elect Directors and shall take action on any matter which may be brought before the meeting under Article IX of these By-Laws. The Chairman shall have the right in his discretion to limit the duration of Subscribers' questions or remarks from the floor to a period of not less than five minutes per Subscriber. If the Annual Meeting shall not have been called and held within six months after the date specified in this Section, any Subscriber may call such meeting at any time thereafter.

SECTION 2.03. *Special Meetings.* Special meetings of Subscribers of the Corporation for any purpose or purposes may be called at any time by the President, by the Board of Directors, or by Subscribers entitled to cast at least 10% of the votes which all Subscribers of the Corporation are entitled to cast at the particular meeting. The Subscribers' petition for such a special meeting shall include the subscription number or the identification number under a group contract of every Subscriber who signs such petition.

At any time, upon written request of any person or persons who have duly called a special meeting, which written request shall state the object of the meeting, it shall be the duty of the Secretary to fix the date of the

meeting to be held at such date and time as the Secretary may fix, not less than ten nor more than 60 days after the receipt of the request, and to give due notice thereof. If the Secretary shall neglect or refuse to fix the date and time of such meeting and give notice thereof, the person or persons calling the meeting may do so.

SECTION 2.04. *Formal Notice of Meetings.* The Secretary shall mail formal notice of every meeting of Subscribers whether Annual or Special to each Subscriber whose address is listed on the records of the Corporation. Where the address of a Subscriber is not so listed, the Secretary shall mail or deliver such notice to the group leader of the group to which such Subscriber belongs, and shall make a diligent effort to insure that the group leader (1) is provided with a copy of the notice for distribution to the Subscriber, and (2) is encouraged to distribute such copy to the Subscriber promptly after receipt thereof. The Secretary may use under this section any class of mail which the Secretary reasonably believes will result in the delivery of substantially all mailed matter to the addressees thereof at least 30 days prior to the day named for the meeting. In addition formal notice of every meeting of Subscribers shall be published in at least two newspapers published in the English language in the City of Philadelphia, one of which shall be the legal newspaper designated by the rules of court for publication of legal notice, at least 45 days prior to the day named for the meeting.

Every formal notice of meeting shall state briefly the purpose or purposes thereof, and no business, other than that specified in such notice and matters germane thereto, shall be transacted at any meeting without further notice to Subscribers not present. The formal notice relating to a meeting of Subscribers at which Directors

are to be elected shall contain the information required by Sections 3.04(h) and 3.06 of these By-Laws.

Whenever the language of a proposed resolution is included in a formal notice of a meeting of Subscribers, the resolution may be adopted at such meeting, with such clarifying or other amendments as do not enlarge its original purpose, without further notice to Subscribers not present.

SECTION 2.05. *Formal Notice to Contain Proxies.* Formal notices of meetings of Subscribers (but not preliminary notices under Section 3.04(d) and (f) of these By-Laws) shall contain a form of proxy which a Subscriber who will be absent from such meeting may use. The form relating to a meeting of Subscribers at which Directors are to be elected shall contain the provisions required by Section 3.06 of these By-Laws. The proxy shall be signed by such Subscriber, and shall include his subscription agreement number or his identification number under his group contract. The proxy agents named in the body of such proxy form shall be three persons selected by the Board of Directors. At a meeting of the Board preceding the mailing and publication of such notice, the Board shall name proxy agents for the ensuing meeting of the Subscribers. If proxy agents are not so selected within 20 days prior to such mailing and publication, the Chairman of the Board may name such proxy agents.

SECTION 2.06. *Quorum, Manner of Acting and Adjournment.* The presence in person (hereinafter defined to include by proxy) of Subscribers entitled to cast 1,000 votes on a particular matter shall constitute a quorum for the purpose of considering such matter. The Subscribers present at a duly organized meeting may continue

to do business until adjournment, notwithstanding withdrawal of enough Subscribers to leave less than a quorum.

If a meeting cannot be organized because a quorum has not attended, the Subscribers present may adjourn the meeting to such time and place as they may determine. At any such adjourned meeting at which a quorum may be present, such business may be transacted as might have been transacted at the meeting as originally called. In case of any meeting called for the election of Directors, those Subscribers who attend the second of such adjourned meetings, though less than a quorum, shall nevertheless constitute a quorum for the purpose of electing Directors. Any meeting at which Directors are to be elected shall be adjourned only from day to day, or for such longer periods not exceeding 15 days each, as the Subscribers present entitled to cast at least a majority of the votes which all members present and voting are entitled to cast, shall direct, until such Directors are elected.

Except as otherwise specified in the Articles or these By-Laws or provided by statute, the acts, at a duly organized meeting, of Subscribers entitled to cast at least a majority of the votes which all Subscribers present and voting are entitled to cast, shall be the acts of the Subscribers.

SECTION 2.07. *Quorum at Adjourned Meetings.* Notwithstanding any contrary provision in these By-Laws, in the case of any meeting called for any other purpose other than the election of Directors, those Subscribers who attend the second of such adjourned meetings, although less than a quorum as fixed in these By-Laws, shall nevertheless constitute a quorum for the purpose of acting upon any resolution or other matter set forth in

the notice of the meeting, if written notice of such second adjourned meeting, stating that those Subscribers who attend shall constitute a quorum for the purpose of acting upon such resolution or other matter, is given to each Subscriber of record entitled to vote at such meeting at least ten days prior to the date named for that meeting.

SECTION 2.08. *Organization.* At every meeting of the Subscribers the Chairman of the Board, or in the case of vacancy in office or absence of the Chairman, one of the following Officers present in the order stated: the Vice Chairman of the Board, the President, the Executive Vice President, the other Vice Presidents in their order of rank as determined from time to time by the Board of Directors, or a Chairman chosen by a majority of the Subscribers present, shall act as presiding officer and the Secretary, or, in his absence, an Assistant Secretary, or in the absence of both the Secretary and Assistant Secretaries, a person appointed by the presiding officer, shall act as Secretary.

SECTION 2.09. *Voting.* Every Subscriber shall be entitled to one vote at every meeting of Subscribers of the Corporation. The vote upon any matter, other than the election of Directors, need not be by ballot unless otherwise directed by the presiding officer. For the purpose of voting for the election of Directors and on any other matter, the presiding officer may require that each Subscriber include his name and his subscription agreement number or his identification number under his group contract on his ballot.

Every Subscriber entitled to vote at a meeting of Subscribers may authorize another person or persons to act for him by proxy; and every reference in these By-Laws to the presence or vote of or action by a Subscriber

shall include the presence or vote of or action taken by a proxy agent of a Subscriber. Every proxy shall be executed in writing by the Subscriber. No proxy shall be valid unless delivered to the Executive Offices of the Corporation, 16th Floor Widener Building, 1333 Chestnut Street, Philadelphia, Pennsylvania 19107, Attention: Corporate Secretary, not later than 4:30 P.M. on the second Friday after the first Tuesday in February, in the case of an Annual Meeting of Subscribers, or on the seventh business day preceding the meeting, in the case of any other meeting of Subscribers. A proxy shall be revocable at will, notwithstanding any other agreement or any provision in the proxy to the contrary, but the revocation of a proxy shall not be effective until written notice thereof has been given to the Secretary of the Corporation. No unrevoked proxy shall be valid after 11 months from the date of its execution. A proxy shall not be revoked by the death or incapacity of the maker, unless, before the vote is counted or the authority is exercised, written notice of such death or incapacity is given to the Secretary of the Corporation. A Subscriber shall not sell his vote or execute a proxy to any person for any sum of money or anything of value.

SECTION 2.10. *Voting Lists.* Any individual who is a Subscriber as shown by the records of the Corporation or by the records of a contracting party shall be entitled to vote in person or by proxy at any meeting of the Subscribers. Whenever it is necessary under these By-Laws to determine the total number of Subscribers of the Corporation as of specific date, such question shall be referred for determination to the consulting actuaries of the Plan, whose determination shall be conclusive. For the purpose of Subscriber petitions under Section 2.03 of this Article and Article IX of these By-Laws the total number

of Subscribers shall be determined at the election of such actuaries either as of the date of the filing of the petition or as of any other date selected by such actuaries within 16 days prior to or after the date of such filing.

SECTION 2.11. *Judges of Election.* In advance of any meeting of Subscribers the Board of Directors may appoint judges of election, who may, but need not, be Subscribers, to act at such meeting or any adjournment thereof. If judges of election are not so appointed, the presiding officer of any such meeting may, and upon the demand of any Subscriber at the meeting and before voting begins, shall appoint judges of election. The number of judges shall be either one or three as determined in the case of judges appointed upon demand of a Subscriber, by the presiding officer. No person who is candidate for office or salaried employee of the Corporation shall act as a judge. In case any person appointed as judge fails to appear or fails or refuses to act, the vacancy may be filled by appointment made by the Board of Directors in advance of the convening of the meeting, or at the meeting by the presiding officer of the meeting.

If judges of election are appointed as aforesaid, they shall determine the number of Subscribers of record and the voting power of each, the Subscribers present at the meeting, the existence of a quorum, the authenticity, validity and effect of proxies, receive votes or ballots, hear and determine all challenges and questions in any way arising in connection with the right to vote, count and tabulate all votes, determine the result, and do such acts as may be proper to conduct the election or vote with fairness to all Subscribers. The judges of election shall perform their duties impartially, in good faith, to the best of their ability, and as expeditiously as is practical. If there are three judges of election, the decision, act or

certificate of a majority shall be effective in all respects as the decision, act or certificate of all.

On request of the presiding officer of the meeting or of any Subscriber, the judges shall make a report in writing of any challenge or question or matter determined by them, and execute a certificate of any fact found by them.

SECTION 2.12. *Determination of Subscribers of Record.* The Board of Directors may fix a time, not more than 70 days prior to the date of any meeting of Subscribers or any adjournment thereof, as a record date for the determination of the Subscribers entitled to notice of, or to vote at, any such meeting, and in such case, if otherwise entitled, only Subscribers of record on the date so fixed, and no others, shall be entitled to notice of, or to vote at, such meeting, notwithstanding any increase or other change in the number of Subscribers on the books of the Corporation after any such record date fixed as aforesaid. The Board of Directors may similarly fix a record date for the determination of Subscribers of record for any other purpose. If no record date is fixed:

(a) The record date for determining Subscribers entitled to notice of or to vote at a meeting of Subscribers shall be at the close of business on the day next preceding the date on which notice is given.

(b) The record date for determining Subscribers for any other purpose shall be at the close of business on the date on which the Board of Directors adopts the resolution relating thereto.

ARTICLE III

BOARD OF DIRECTORS

SECTION 3.01. *Powers.* The Board of Directors shall have full power to conduct, manage, and direct the busi-

ness and affairs of the Corporation, and all powers of the Corporation, except those specifically reserved or granted to the Subscribers by statute or by the Articles or these By-Laws, are hereby granted to and vested in the Board of Directors.

SECTION 3.02. *Qualifications.* Each Director of the Corporation shall be a natural person of at least 18 years of age, and a Subscriber of the Corporation residing within the area served by the Corporation but need not be a resident of Pennsylvania. Upon attaining the age of 75 years, a Director shall thereupon cease to be a Director, but may then or thereafter become a Director Emeritus if appointed pursuant to Section 3.03(e) of this Article. The preceding sentence shall not be applicable to any Directors in office on the date of the original adoption of such sentence and shall not disqualify such a person from eligibility to reelection as a Director after having attained age 75. No more than three of the Directors may be trustees or directors of hospitals: and no more than three may be physicians. No person shall be eligible for election to the Board of Directors or to continue as a Director who is a Provider of services or an employee (other than a physician) of a Provider of services to a Subscriber of this Corporation or his eligible dependents. For the purposes of this Section the term "Provider of Services" shall mean a facility defined as such in Title XVIII of the Social Security Act or any similar facility.

A person who violates Section 3.19(a) of this Article shall not be eligible to continue as a Director. The Board of Directors shall forthwith remove from office any Director who becomes ineligible to continue in office as a Director of the Corporation. If nominations have been called for as provided in these By-Laws, only candidates who have been nominated in accordance with these By-Laws shall be eligible for election.

SECTION 3.03. *Number and Term of Office.*

(a) The Board of Directors shall consist of 34 Elective Directors, and the ex-officio Members provided for in subsection (d) of this Section.

(b) Except as provided in subsection (c) of this Section or in Section 3.10(e) of this Article, each Elective Director shall serve until the third Annual Meeting following his election by the Subscribers and until his successor shall have been elected and qualified, or until his earlier death, resignation or removal.

(c) The terms of Directors to be elected at any meeting of Subscribers called for the election of Directors shall be so staggered that, as nearly as possible, an equal number of Directors shall be elected in successive years.

(d) There shall be the following ex-officio Members of the Board of Directors, who, except in the case of the President and Executive Vice President, shall have the right to vote:

(1) The President

(2) The Executive Vice President

(3) The Chairman of the Consumer Advisory Committee

(4) The Vice Chairman of the Consumer Advisory Committee.

(e) The Board may at its discretion appoint any Member of the Board to the status of a Director Emeritus, if:

(1) The appointment is made with the consent of the Director; and

(2) The Director has served as a Director of the Corporation for not less than ten years.

A Director Emeritus, until his death, resignation or removal, shall have all the rights of a Director, except the right to vote.

(f) At any Annual Meeting the Subscribers shall elect, in addition to Directors elected for three-year terms, a Director to serve for a one-year or a two-year term, as appropriate, to fill the unexpired portion of the term with respect to each vacancy which under Section 3.10(e)(1) or (2) of this Article cannot be filled by the Board of Directors.

SECTION 3.04. *Nominations of Elective Directors.* The Elective Directors shall be nominated in the following manner:

(a) Prior to the Annual Meetings in 1978 and each third year thereafter the Governor of the Commonwealth of Pennsylvania and the Mayor of the City of Philadelphia shall each nominate one eligible person for the office of Elective Director. Prior to the Annual Meetings in 1977 and each third year thereafter the President of the Philadelphia City Council and the Chairman of the Board of Commissioners of Bucks County, Pennsylvania shall each nominate one eligible person for the office of Elective Director. Prior to the Annual Meetings in 1976 and each third year thereafter the Chairmen of the respective Boards of Commissioners of Chester, Delaware and Montgomery Counties, Pennsylvania shall each nominate one eligible person for the office of Elective Director.

(b) The Chairman of the Board shall by the first Tuesday in September, or as soon thereafter as practicable, appoint a Nominating Committee consisting of at least nine members of whom:

(1) two shall be Elective Directors who were nominated for election to the Board by public officials as provided in subsection (a) of this Section, if there are at least two such Elective Directors serving on the Board, and, if not, the Chairman and Vice Chairman of the Consumer Advisory Committee, in that order as required, shall serve.

(2) two at least shall be Subscribers who are not otherwise affiliated with the Corporation or with any Provider of health care services.

(c) The Nominating Committee shall choose a Chairman, who shall notify the public officials specified in subsection (a) of this Section of their right to nominate candidates for the office of Elective Director and shall fix in such notice a date, which shall not be less than three weeks after the giving of such notice, by which the nominations of eligible persons by such public officials shall be made and delivered in writing to the Chairman.

(d) On or before the first Friday following the first Tuesday in September, or as soon thereafter as practicable, the Secretary shall cause to be published in at least two newspapers published in the English language in the City of Philadelphia, one of which shall be the legal newspaper designated by the rules of court for the publication of legal notices, an initial notice of the Annual Meeting of Subscribers, which shall:

(1) State that a Nominating Committee has been appointed and shall set forth the purpose thereof.

(2) Set forth the names of the individuals comprising the Nominating Committee.

(3) Advise the public that any Subscriber may have such Subscriber's name considered by the Nominating Committee by submitting a resume to the Secretary of the Corporation on or before the third Monday of September.

The Secretary shall promptly deliver all such resumes to the Nominating Committee.

(e) Thereafter, the Nominating Committee shall meet, and by the second Monday in October shall submit in writing to the Secretary of the Corporation the names of the eligible persons nominated by public officials pursuant to subsection (a) of this Section and such a number of names of other eligible persons so that the total number of nominations for the office of Elective Director submitted by the Committee shall equal the number of Elective Directors to be elected at the next Annual Meeting of Subscribers as provided in Section 3.03(f) of this Article.

(f) On or before the first Friday following the second Monday of October, or as soon thereafter as practicable, the Secretary shall cause to be published in the manner provided by Subsection (d) of this Section a second notice of the Annual Meeting of Subscribers, which shall:

(1) List the individuals nominated by the Nominating Committee and the public officials pursuant to this Section.

(2) Summarize the provisions of subsection (g) of this Section relating to the procedures for the making of additional nominations.

(g) Additional nominations may be submitted in writing to the Secretary of the Corporation on or before the fourth Monday of November, in the manner in which proxies are filed under Section 2.09 of these By-Laws. Each such nomination shall be in the form of a petition signed by at least 300 Subscribers, shall contain the name of such additional nominee, the name of any proxy agent or agents who will act for Subscribers who desire to support such nominee, and shall include a statement that the nominee is eligible to serve as an Elective Director under the By-Laws together with the subscription agreement numbers or identification numbers under a group contract of the nominee and of all the Subscribers who signed the petition. Endorsed on or accompanying the petition shall be the written acceptance of nomination by the nominee and the written acceptance of designation by the proxy agent or agents named in the petition. A Subscriber may sign as many nominating petitions as there are Directors to be elected.

(h) On or before the second Friday of December, or as soon thereafter as practicable, the Secretary shall publish formal notice of the Annual Meeting of Subscribers in the manner provided by Section 2.04 of these By-Laws. Such notice shall include the names of all individuals duly nominated for the office of Elective Director pursuant to these By-Laws, grouped under Nominating Committee nominees, public official nominees and additional nominees headings, as appropriate.

SECTION 3.05. *Substitute Nominations.* The Board of Directors, at any time before the commencement of balloting, may substitute another candidate for any candidate nominated by the Nominating Committee who for

any reason shall be unavailable for election at the Annual Meeting. If a candidate nominated by a public official pursuant to subsection (a) of Section 3.04 of this Article is unavailable, the Secretary shall request the appropriate public official or officials to submit the name of a substitute candidate, who if eligible shall be substitute nominee.

SECTION 3.06. *Proxies and Proxy Agents.* The form of proxy accompanying the formal notice of a meeting of Subscribers at which Directors are to be elected shall contain the names of the proxy agents designated pursuant to Section 2.05 of these By-Laws, who shall be identified as "Blue Cross Proxy Agents." The formal notice of an Annual Meeting of Subscribers shall state that the Blue Cross Proxy Agents will vote for the Nominating Committee nominees and the public official nominees identified in the notices. The notice shall also state the names of proxy agents for additional nominees, and the notice and form of proxy shall contain instructions as to the method whereby a Subscriber may designate on the form of proxy one or more proxy agents for additional nominees in lieu of the Blue Cross Proxy Agents named in the body of the form of proxy.

SECTION 3.07. *Election.* Except in the case of interim vacancies, Directors shall be elected in the following manner by the Subscribers:

(a) The candidates receiving the highest number of votes, up to the number of Directors to be elected, shall be elected.

(b) In the event that the number of trustees or physicians who receive sufficient votes at any meeting of Subscribers to be elected as Directors shall exceed

the number who may hold office by reason of the limitations on the maximum number of trustees or physicians set forth in Section 3.02 of this Article, then only as many trustees and physicians shall be declared elected as will comply with such limitations. If there are at the time less than three trustees or physicians holding terms which do not expire at such meeting, the trustees or physicians declared elected at such meeting shall be those receiving the highest number of votes of the trustees or physicians who received sufficient votes to be elected as Directors up to the number of such Directors who may be elected by reason of the limitations in Section 3.02 of this Article.

SECTION 3.08. *Organization.* At every meeting of the Board of Directors the Chairman of the Board, or, in the case of a vacancy in the office or absence of the Chairman, one of the following officers present in the order stated: the Vice Chairman of the Board, the President, the Executive Vice President, the other Vice Presidents in their order of rank as determined from time to time by the Board of Directors, or a Chairman chosen by a majority of the Directors present, shall preside; and the Secretary, or, in his absence, an Assistant Secretary, or in the absence of the Secretary and the Assistant Secretaries, any person appointed by the Chairman of the meeting, shall act as Secretary.

SECTION 3.09. *Resignations.* Any Director of the Corporation may resign at any time by giving written notice to the Secretary of the Corporation. Such resignation shall take effect at the date of the receipt of such notice or at any later time specified therein and, unless

otherwise specified therein, the acceptance of such resignation shall not be necessary to make it effective.

SECTION 3.10. *Vacancies.*

(a) The Board of Directors may declare vacant the office of a Director

(1) if he is declared of unsound mind by an order of court, or convicted of felony, or for any other proper cause,

(2) if within 60 days after notice of his election, he does not accept such office either in writing or by attending a meeting of the Board of Directors,

(3) if any Director shall have absented himself from three successive meetings and no satisfactory explanation of such absence shall have been made to the Board, or

(4) if he becomes disqualified pursuant to Section 3.02 of this Article.

(b) The office of any Elective Director who was nominated by a public official pursuant to subsection (a) of Section 3.04 may be declared vacant by the Board of Directors at the end of the first or second year of his term upon the receipt of a written notice from the public official responsible for that nomination requesting that the Board declare the office vacant. The Board of Directors shall then fill the vacancy pursuant to subsection (d) of this Section.

(c) Any interim vacancy or vacancies in the Board of Directors caused by death, resignation, removal in any manner other than under the provisions of Section 3.11 of this Article, disqualification, an increase in the number of Directors, or any other cause, may be filled by a vote

of the majority of the remaining Members of the Board of Directors though less than a quorum, at any regular or special meeting.

(d) If a vacancy occurs by reason of the death, resignation or removal of a Director nominated by a public official designated in subsection (a) of Section 3.04 of this Article, the Board of Directors shall fill the vacancy from among a person or persons nominated in writing by such public official.

(e) Directors elected to fill interim vacancies shall continue in office for the unexpired portion of the term and until their successors shall have been elected and qualified, or until their earlier death, resignation or removal, except in the case of:

(1) a vacancy in the office of a Director whose regular term expires at the third succeeding Annual Meeting, or

(2) a vacancy occurring more than six months before the next annual Meeting in the office of a Director whose regular term expires at the second succeeding Annual Meeting;

In either of the foregoing cases the Board may fill the vacancy only until the next Annual Meeting occurring more than six months after the occurrence of the vacancy, at which time a successor shall be elected by the Subscribers for the balance of the unexpired portion of the term.

SECTION 3.11. *Removal.* At any special or other meeting called for the purpose of removing or electing Directors, the entire Board of Directors, or any individual Director, may be removed from office without assigning any cause, by the vote of Subscribers entitled to cast at

least 10% of the votes which all Subscribers would be entitled to cast at any Annual Meeting or special meeting, provided such vote constitutes a majority vote of those present and voting. In case the Board or any one or more Directors is so removed, new Directors may be elected at the same meeting.

SECTION 3.12. *Place of Meeting.* The Board of Directors may hold its meetings at such place or places within Pennsylvania or elsewhere as the Board of Directors may from time to time appoint, or as may be designated in the notice calling the meeting.

SECTION 3.13. *Organization Meeting.* Immediately after each annual election of Directors or after a meeting at which the entire Board of Directors is elected, the Board of Directors shall meet for the purpose of organization, election of officers, and the transaction of other business, at the place where said election of Directors was held. Notice of such meeting need not be given. Such organization meeting may be held at any other time or place which shall be specified in a notice given as hereinafter provided for special meetings of the Board of Directors.

SECTION 3.14. *Regular Meetings.* Regular meetings of the Board of Directors shall be held at such time and place as shall be designated from time to time by resolution of the Board of Directors. If the date fixed for any such regular meeting is a legal holiday under the laws of the State where such meeting is to be held, then the meeting shall be held on the next succeeding business day, not a Saturday, or at such other time as may be determined by resolution of the Board of Directors. At such meetings, the Directors shall transact such business as may properly be brought before the meeting. Notice

of regular meetings need not be given unless required by law or these By-Laws.

SECTION 3.15. *Special Meetings.* Special meetings of the Board of Directors shall be held whenever called by the Chairman, by the Vice Chairman, by the President or by two or more of the Elective Directors. Notice of each such meeting shall be given to each Director by telephone or in writing at least 24 hours (in the case of notice by telephone) or 48 hours (in the case of notice by telegram) or five days (in the case of notice by mail) before the time at which the meeting is to be held. Every such notice shall state the time and place of the meeting.

Notice of any meeting of the Board of Directors during any emergency resulting from warlike damage, or an attack on the United States, or any nuclear or atomic disaster, shall be given only to such of the Directors as it may be feasible to reach at the time and by such means as may be feasible at the time, including publication or radio. To the extent required to constitute a quorum at any meeting of the Board of Directors during such an emergency, the officers of the Corporation who are present shall be deemed, in order of rank and within the same rank in order of seniority as determined, from time to time, by the Board of Directors, Directors for such meeting.

SECTION 3.16. *Quorum, Manner of Acting, and Adjournment.* Except as otherwise provided in Section 3.15 of this Article, 13 Elective Directors shall be present at each meeting in order to constitute a quorum for the transaction of business. Except as otherwise specified in the Articles or these By-Laws or provided by statute, the acts of a majority of the Directors present at a duly organized meeting shall be the acts of the Board of

Directors. In the absence of a quorum, a majority of the Directors present may adjourn the meeting from time to time until a quorum is present. The Directors shall act only as a Board, and the individual Directors shall have no power as such, except that any action which may be taken at a meeting of the Board may be taken without a meeting, if a consent or consents in writing setting forth the action so taken shall be signed by all of the Elective Directors in office filed with the Secretary of the Corporation.

SECTION 3.17. *Executive and Other Committees.*

(a) The Board of Directors, by resolution adopted by a majority of the Directors in office, may designate an Executive Committee and one or more other committees. The Executive Committee and the Audit Committee shall each consist of at least seven Directors, and, except as otherwise provided in these By-Laws, any other committees shall consist of three or more Directors. The Executive Committee shall include at least two Elective Directors who were nominated for election to the Board by public officials as provided in Section 3.04(a) of this Article, if there are two such Elective Directors serving on the Board. Each committee of the Board shall serve at the pleasure of the Board. The Board may designate one or more Directors as alternate members of any committee to replace any absent or disqualified member at any meeting of the committee. In the event of absence or disqualification of a member of any committee, and of the alternate or alternates, if any, designated for such member, the member or members thereof present at any meeting and not disqualified from voting, whether or not he or they constitute a quorum, may unanimously appoint another Director to act at the meeting in the place of any such absent or disqualified member.

(b) The Executive Committee shall have and may exercise all of the powers and authority of the Board of Directors except that the Executive Committee shall not have any power or authority as to the following:

(1) The submission to Subscribers of any action requiring approval of Subscribers [under these By-Laws or the Non-profit Corporation Law of 1972].

(2) The filing of vacancies in the Board of Directors.

(3) The adoption, amendment or repeal of the By-Laws.

(4) The amendment or repeal of any resolution of the Board.

(c) The Audit Committee may include any Member of the Board of Directors of the Corporation except the President and Executive Vice President of the Corporation. The Audit Committee shall review all reports of the firm of independent certified public accountants selected by the Board and such other matters as may from time to time be referred to this Committee by the Board, by the Executive Committee, by the officers or by the auditors, and shall annually review the adequacy of bonding arrangements under Section 6.06 of these By-Laws and of all arrangements for the receipt, custody and disbursement of funds including banking and custody resolutions and authorizations, and shall duly report their findings and recommendations as appropriate.

(d) The Personnel Committee shall consider and make recommendations to the Board of Directors concerning:

(1) All salaries requiring Board approval except those of officers designated by resolution of the Board.

(2) All officers to be elected by the Board.

(3) The operation and provisions of the Revised Retirement Plan (sometimes referred to as the Pension Plan).

(4) Any other matters which the Board of Directors shall refer to the Personnel Committee.

(e) No committee of the Board, other than the Executive Committee, shall, pursuant to resolution of the Board or otherwise, exercise any of the powers or authority vested by law in the Board of Directors as such, but any committee of the Board may make recommendations to the Board of Directors or to the Executive Committee concerning the exercise of such powers and authority.

(f) A majority of the Directors in office designated to any committee, or Directors designated to replace them as provided in this Section, shall be present at each meeting of any such committee to constitute a quorum for the transaction of business and the acts of a majority of the Directors in office designated to a committee or their replacements shall be the acts of the committee.

(g) Each committee shall keep regular minutes of its proceedings and report promptly such proceedings to the Board of Directors when required for approval or disapproval; but any such disapproval shall not affect the rights of third parties accruing prior to such disapproval.

(h) Those portions of Sections 3.14, 3.15 and 3.16 of this Article, as may be applicable, shall apply to committees of the Board of Directors.

SECTION 3.18. *Consumer Advisory Committee.*

(a) There shall be a Consumer Advisory Committee to the Board which shall consist of seven members, who

shall have the qualifications prescribed for Directors by Section 3.02 of this Article and who shall serve without compensation, one each to be appointed by the Governor of Pennsylvania, the Mayor of the City of Philadelphia, the President of the Philadelphia City Council, and the Chairmen of the respective Boards of Commissioners of the Counties of Bucks, Chester, Delaware and Montgomery, Pennsylvania. The terms of the members of the Consumer Advisory Committee to be appointed in July 1973 shall extend to the Annual Meeting in 1975. Thereafter the seven appointed members of the Consumer Advisory Committee shall be appointed annually for terms of one year extending from one Annual Meeting to the next when their membership on the Committee shall then terminate unless they are reappointed.

(b) The primary function and concern of the Committee shall be to advise the Board of Directors from time to time how, in the opinion of the Committee, the Plan can best:

(1) Improve its coverage of, and service to, its Subscribers.

(2) Obtain for its Subscribers high quality health care at minimum cost.

The Committee shall report only to the Board of Directors, except that it may also present a report of its activities at any Annual Meeting of the Subscribers. Copies of the Committee's reports to the Board may be sent only to the Insurance Commissioner, and a copy of any report by the Committee to an Annual Meeting of the Subscribers shall be delivered to the Secretary of the Corporation not less than two weeks prior to such Meeting.

(c) There shall be a Chairman and Vice-Chairman of the Committee each of whom shall be one of the seven members of that Committee appointed by public officials under subsection (a) of this Section and not a member of the Committee elected under subsection (d) of this Section and who shall be elected only by the vote of at least four members of that Committee appointed by public officials under subsection (a) of this Section.

(d) The seven appointed members of the Committee shall be empowered by vote of at least four members to elect to its membership not more than seven additional members from Consumer Groups as it deems appropriate, and such additional members shall serve until the next Annual Meeting.

(e) The Committee shall meet at least quarterly with a senior officer of the Corporation present, and after such meeting promptly submit the minutes of such meeting and report its recommendations, if any, in writing to the Board of Directors through the Chairman or Vice Chairman of the Committee.

(f) The Chairman of the Board shall call any organizational meeting of the Committee by letters to each of the seven Committee members appointed under subsection (a) of this Section. The quorum for such organizational meeting shall consist of at least five of the appointed members. The quorum for all other meetings of the Committee shall consist of a majority of the then members of that Committee. Those portions of Sections 3.14, 3.15 and 3.16 of this Article, as may be applicable and not inconsistent with the provisions of this section, shall apply to the Consumer Advisory Committee.

SECTION 3.19. *Interested Directors or Officers; Quorum.*

(a) No Director who is a physician or a hospital employee, officer, trustee, director or affiliate shall participate directly on behalf of the Corporation or on behalf of a Provider of health care services in the negotiation of any contract between the Corporation and a Provider or vote on the question of the authorization, approval or ratification of such a contract.

(b) No contract or transaction between the Corporation and one or more of its Directors or Officers, or between the Corporation and any other corporation, partnership, association, or other organization in which one or more of its Directors or Officers are directors or officers, or have a financial interest, shall be void or voidable solely for such reason, or solely because the Director or Officer is present at or participates in the meeting of the Board which authorizes the contract or transaction, or solely because his or their votes are counted for such purpose, if:

(1) The material facts as to his relationship or interest and as to the contract or transaction are disclosed to the Board of Directors and the Board in good faith authorizes the contract or transaction by the affirmative votes of a majority of the disinterested Directors, even though the disinterested Directors are less than a quorum; or

(2) The contract or transaction is fair as to the Corporation as of the time it is authorized, approved or ratified, by the Board of Directors.

(c) Common or interested Directors may be counted in determining the presence of a quorum at a meeting of the Board of Directors which authorizes a contract or transaction specified in this Section.

Exhibit 2

ARTICLE IV

Notice—Waivers—Meetings

Section 4.01. *Notice, What Constitutes.* Except as provided in Section 2.04 of these By-Laws whenever written notice is required to be given to any person under the provisions of the Articles, these By-Laws, or the Nonprofit Corporation Law of 1972, it may be given to such person, either personally or by sending a copy thereof through the mail, or by telegraph, charges prepaid, to his address appearing on the books of the Corporation, or in the case of directors supplied by him to the Corporation for the purpose of notice. If the notice is sent by mail or by telegraph, it shall be deemed to have been given to the person entitled thereto when deposited in the United States mail or with a telegraph office for transmission to such person. A notice of a meeting shall specify the place, day and hour of the meeting.

When a meeting is adjourned, it shall not be necessary to give any notice of the adjourned meeting or of the business to be transacted thereat, other than by announcement at the meeting at which such adjournment is taken.

Section 4.02. *Waivers of Notice.* Whenever any written notice is required to be given under the provisions of the Articles, these By-Laws, or the Nonprofit Corporation Law of 1972, a waiver thereof in writing, signed by the person or persons entitled to such notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice. Except in the case of a special meeting of Subscribers, neither the business to be transacted at, nor the purpose of, the meeting need be specified in the waiver of notice of such meeting.

Exhibit 2

Attendance of a person at any meeting shall constitute a waiver of notice of such meeting, except where a person attends a meeting for the express purpose of objecting to the transaction of any business because the meeting was not lawfully called or convened.

Section 4.03. *Exception to Requirement of Notice.* Wherever any notice or communication is required to be given to any person under the provisions of the Articles, of these by-laws or the Nonprofit Corporation Law of 1972, or by the terms of any agreement or other instrument or as a condition precedent to taking any corporate action, and communication with such person is then unlawful, the giving of such notice or communication to such person shall not be required and there shall be no duty to apply for a license or other permission to do so.

Section 4.04. *Conference Telephone Meetings.* One or more Directors may participate in a meeting of the Board, or a committee of the Board, by means of conference telephone or similar communications equipment by means of which all persons participating in the meeting can hear each other. Participation in a meeting pursuant to this Section shall constitute presence in person at such meeting.

ARTICLE V

Officers

Section 5.01. *Number, Qualifications and Designation.* The Officers of the Corporation shall be a Chairman of the Board, one or more Vice Chairmen of the Board, a President, an Executive Vice President, one or more other Vice Presidents, a Treasurer, a Secretary and such other officers as may be elected in accordance with the provisions of Section 5.03 of this Article. Any two or more offices may be held by the same person except that no

person may hold more than one of the following offices: Chairman of the Board, Vice Chairman of the Board, President, Executive Vice President, Treasurer and Secretary. The Officers, except the Treasurer, shall be natural persons of full age; the Treasurer, however, may be a corporation, but if a natural person shall be of full age.

SECTION 5.02. *Election and Term of Office.* The Officers of the Corporation shall be elected annually by the Board of Directors, and each such Officer shall hold his office until the next annual organization meeting of Directors and until his successor shall have been duly chosen and qualified, or until his earlier death, resignation, or removal. The election or appointment of an officer shall not of itself create any contract right to employment for any term, it being the intention of these By-Laws that all officers shall serve at the pleasure of the Board of Directors.

SECTION 5.03. *Subordinate Officers, Committees and Agents.* The Board of Directors may from time to time elect such other officers and appoint such committees, employees or other agents as the business of the Corporation may require, including one or more Assistant Vice Presidents, one or more Assistant Secretaries, and one or more Assistant Treasurers, each of whom shall hold office for such period, have such authority, and perform such duties as are provided in these By-Laws, or as the Board of Directors may from time to time determine. The Board of Directors may delegate to any Officer or committee the power to retain or appoint employees or other agents, or committees thereof, and to prescribe the authority and duties of such persons. At the annual organization meeting of the Board of Directors, the Board shall appoint a General Counsel and a firm of independent certified public

accountants for the Corporation to serve at the pleasure of the Board.

SECTION 5.04. *Resignations.* Any Officer or agent may resign at any time by giving written notice to the Board of Directors or to the President or the Secretary of the Corporation. Any such resignation shall take effect at the date of the receipt of such notice or at any later time specified therein and, unless otherwise specified therein, the acceptance of such resignation shall not be necessary to make it effective.

SECTION 5.05. *Removal.* Any Officer, committee, employee or other agent of the corporation may be removed, either for or without cause, by the Board of Directors or other authority which elected, retained or appointed such Officer, committee or other agent whenever in the judgment of such authority the best interests of the Corporation will be served thereby, but such removal shall be without prejudice to the contract rights, if any, of persons so removed.

SECTION 5.06. *Vacancies.* A vacancy in any office because of death, resignation, removal, disqualification, or any other cause, shall be filled by the Board of Directors and if the office is one for which these By-Laws prescribe a term, shall be filled for the unexpired portion of the term.

SECTION 5.07. *General Powers.* All Officers of the Corporation, as between themselves and the Corporation, shall, respectively, have such authority and perform such duties in the management of the property and affairs of the Corporation as may be determined by resolution or orders of the Board of Directors, or in the absence of

controlling provisions in a resolution or orders of the Board of Directors, as may be provided in these By-Laws.

SECTION 5.08. *Chairman.* The Chairman of the Board shall preside at all meetings of the Board of Directors and of the Subscribers of the Corporation. He shall act as liaison between the Board of Directors and the President of the Corporation with particular reference to the formulation and implementation of Corporate policy in matters affecting the Corporation, the Subscribers, the Insurance Department of the Commonwealth and contracts with hospitals and the public generally. He shall submit to the Board nominations of Directors to serve on the Executive Committee, the Audit Committee and the Personnel Committee, and on such other Committees of the Board as may exist from time to time. He shall serve without compensation and shall not be associated with or employed by any hospital in any capacity. He or his designee shall also act as liaison between the Consumer Advisory Committee, the Corporation and the Board of Directors, and as such may attend all meetings of that Committee.

SECTION 5.09. *Vice Chairmen.* In the absence of the Chairman, or in the event of his inability or refusal to act, the Vice Chairmen, in the order of their rank as determined from time to time by the Board of Directors, shall exercise all the powers and perform all the duties of the Chairman.

SECTION 5.10. *President.* The President shall be the chief executive officer of the Corporation and shall assist the Chairman of the Board in the formulation of Corporation policy for submission to the Board or the Executive Committee and be responsible for its implementation.

He may sign on behalf of the Corporation any documents or instruments which the Board of Directors or the Executive Committee have authorized to be executed, except in cases where the signing and execution thereof shall be expressly delegated by the Board of Directors or by these By-Laws to some other Officer or agent of the Corporation, or shall be required by law to be otherwise signed or executed; and in general, he shall perform all duties incident to the office of President in accordance with the provisions of this Article, and such other duties as may be prescribed by the Board of Directors or the Executive Committee from time to time. He shall preside at all meetings of the Executive Committee.

SECTION 5.11. *Executive Vice President.* The Executive Vice President shall perform such duties as from time to time may be assigned to him by the President, the Board of Directors or the Executive Committee. In the absence of the President or in the event of his inability or refusal to act, the Executive Vice President shall perform the duties of President and when so acting shall have all the powers, and be subject to all the restrictions upon the President.

SECTION 5.12. *Vice Presidents.* In the absence of the President and the Executive Vice President or in the event of their inability or refusal to act, the Vice Presidents in order of their rank, as determined from time to time by the Board of Directors, shall perform the duties of the President and Executive Vice President and when so acting shall have all the powers of, and be subject to all the restrictions upon, the President or Executive Vice President. Vice Presidents shall perform such other duties as from time to time may be assigned to them by the President, the Executive Vice President, the Board of Directors or the Executive Committee.

SECTION 5.13. *The Treasurer.* The Treasurer shall have or provide for the custody of the funds or other property of the Corporation and shall keep a separate book account of the same to his credit as Treasurer; shall collect and receive or provide for the collection and receipt of moneys earned by or in any manner due to or received by the Corporation; shall deposit all funds in his custody as Treasurer in such banks or other places of deposit as the Board of Directors may from time to time designate; shall, whenever so required by the Board of Directors, render an account showing his transactions as Treasurer, and the financial condition of the Corporation; and, in general, shall discharge such other duties as may from time to time be assigned to him by the Board of Directors, the Executive Committee, the President, or the Executive Vice President. In the absence of the Treasurer or his inability to act, his duties shall be performed by any Assistant Treasurer.

SECTION 5.14. *Secretary.* The Secretary shall keep the minutes of the meetings of the Subscribers of the Corporation and of the Board of Directors in one or more books provided for that purpose; shall notify Members of the Board of Directors of their election; shall see that all notices are duly given in accordance with the provisions of these By-Laws; shall be custodian of the corporate records and of the seal of the Corporation and see that the seal of the Corporation is affixed to all instruments and documents, the execution of which has been authorized by the Board of Directors or the Executive Committee; shall keep a record of the post office address of each Director; and in general shall perform all duties incident to the office of Secretary and such other duties as may be assigned to him by the President, the Executive Vice President, the Board of Directors or the Executive

Committee. In the absence of the Secretary or his inability to act, his duties shall be performed by any Assistant Secretary.

SECTION 5.15. *Assistant Treasurers and Assistant Secretaries.* The Assistant Treasurers and Assistant Secretaries shall perform such duties as from time to time shall be assigned to them by the Treasurer or Secretary, respectively, or by the President, the Executive Vice-President, the Board of Directors or the Executive Committee.

SECTION 5.16. *Salaries.* The salaries of the Officers elected by the Board of Directors shall be fixed from time to time by the Board of Directors or by such Officer as may be designated by resolution of the Board. The salaries or other compensation of any other officers, employees and other agents shall be fixed from time to time by the Officer or committee to which the power to elect such officers or to retain or appoint such employees or other agents has been delegated pursuant to Section 5.03 of this Article. No Director shall receive any salary or other compensation for his services as such. Officers of the Corporation, excluding the Chairman of the Board and the Vice Chairman of the Board, may receive compensation for their services as Officers of the Corporation.

ARTICLE VI

CONTRACTS, LOANS, CHECKS, DEPOSITS AND INVESTMENTS

SECTION 6.01. *Contracts.* The Board of Directors may authorize any Officer or agent to enter into any contract or to execute and deliver any subscription agreement or instrument in the name of and on behalf of the Corpora-

tion, and such authority may be general or confined to specific instances.

SECTION 6.02. *Loans.* No loans shall be contracted on behalf of the Corporation and no evidences of indebtedness shall be issued in its name unless authorized by a resolution of the Board of Directors.

SECTION 6.03. *Checks.* All checks, drafts, bills of exchange or other orders in writing for the payment of money, notes or other evidences of indebtedness issued in the name of the Corporation, shall be signed in such manner, as the Board of Directors may from time to time direct.

SECTION 6.04. *Deposits.* All funds of the Corporation not otherwise employed shall be deposited from time to time to the credit of the Corporation in such banks, trust companies or other depositories as the Board of Directors may from time to time direct.

SECTION 6.05. *Investments.* The funds of the Corporation equal at least to its reserves shall, subject to the provisions of Chapter 61 of Title 40 of the Consolidated Pennsylvania Statutes (relating to hospital plan corporations) or amendments thereto, be invested in compliance with the requirements for the investment of the capital and reserves of life insurance companies. The funds of the Corporation equal to its surplus shall, subject to the said Act or amendments thereto, be invested in compliance with the requirements for the investment of surplus of life insurance companies.

SECTION 6.06. *Bonds.* All officers and employees shall give bond for the faithful discharge of their duties in

such sum and with such surety or sureties as the Board of Directors shall require.

SECTION 6.07. *Annual Report of Directors.* The Board of Directors shall present annually to the Subscribers at the Annual Meeting a Report, verified by the President and Treasurer or by a majority of the Directors, showing in appropriate detail the following:

(1) The assets and liabilities of the Corporation as of the end of the fiscal year immediately preceding the date of the Report.

(2) The principal changes in assets and liabilities during the year immediately preceding the date of the Report.

(3) The revenue or receipts of the Corporation, both unrestricted and restricted to a particular purpose, for the year immediately preceding the date of the Report.

(4) The expenses or disbursements of the Corporation, for both general and restricted purposes, during the year immediately preceding the date of the Report.

(5) The estimated number of Subscribers of the Corporation as of the date of the Report, together with a statement of increase or decrease in such number during the year immediately preceding the date of the Report.

The annual Report of the Board of Directors or other body shall be filed with the minutes of the meeting of the Subscribers.

Exhibit 2

ARTICLE VII

Indemnification of Directors, Officers, Etc.

Section 7.01. *Directors and Officers; Third Party Actions.* The Corporation shall indemnify any Director or Officer of the Corporation who was or is a party or is threatened to be made a party to any threatened, pending or completed action, suit or proceeding, whether civil, criminal, administrative or investigative (other than an action by or in the right of the Corporation) by reason of the fact that he is or was a representative of the Corporation (which, for the purposes of this Article, shall mean a Director, Officer, employee or agent of the Corporation, or a person who is or was serving at the request of the Corporation as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other enterprise) against expenses (including attorneys' fees), judgments, fines and amounts paid in settlement actually and reasonably incurred by him in connection with such action, suit or proceeding if he acted in good faith and in a manner he reasonably believed to be in, or not opposed to, the best interests of the Corporation, and, with respect to any criminal action or proceeding, had no reasonable cause to believe his conduct was unlawful. The termination of any action, suit or proceeding by judgment, order, settlement, conviction, or upon a plea of nolo contendere or its equivalent, shall not, of itself, create a presumption that the person did not act in good faith and in a manner which he reasonably believed to be in, or not opposed to, the best interests of the Corporation, and, with respect to any criminal action or proceeding, had reasonable cause to believe that his conduct was unlawful.

Exhibit 2

Section 7.02. *Directors and Officers; Derivative Actions.* The Corporation shall indemnify any Director or Officer of the Corporation who was or is a party or is threatened to be made a party to any threatened, pending or completed action or suit by or in the right of the Corporation to procure a judgment in its favor by reason of the fact that he is or was a representative of the Corporation, against expenses (including attorneys' fees) actually and reasonably incurred by him in connection with the defense or settlement of such action or suit if he acted in good faith and in a manner he reasonably believed to be in, or not opposed to, the best interests of the Corporation and except that no indemnification shall be made in respect of any claim, issue or matter as to which such person shall have been adjudged to be liable for negligence or misconduct in the performance of his duty to the Corporation unless and only to the extent that the court of common pleas of the county in which the registered office of the Corporation is located or the court in which such action or suit was brought shall determine upon application that, despite the adjudication of liability but in view of all the circumstances of the case, such person is fairly and reasonably entitled to indemnity for such expenses which the court of common pleas or such other court shall deem proper.

Section 7.03. *Employees and Agents.* To the extent that a representative of the Corporation who neither was nor is a Director or Officer of the Corporation has been successful on the merits or otherwise in defense of any action, suit or proceeding referred to in Sections 7.01 and 7.02 of this Article or in defense of any claim, issue or matter therein, he shall be indemnified against expenses (including attorneys' fees) actually and reasonably incurred by him in connection therewith. Such a representa-

tive shall also be indemnified by the Corporation in any other circumstances to any extent if the Corporation would be required by Section 7.01 or 7.02 of this Article to indemnify such person in such circumstances to such extent if he were or had been a Director or Officer of the Corporation.

SECTION 7.04. *Procedure for Effecting Indemnification.* Indemnification under Sections 7.01, 7.02 or 7.03 of this Article shall be made when ordered by court (in which case the expenses, including attorneys' fees, of the representative in enforcing such right of indemnification shall be added to and be included in the final judgment against the Corporation) and may be made in the specific case upon a determination that indemnification of the representative is required or proper in the circumstances because he has met the applicable standard of conduct set forth in Section 7.01 or 7.02 of this Article. Such determination shall be made:

(1) By the Board of Directors by a majority vote of a quorum consisting of Directors who were not parties to such action, suit or proceeding,

(2) If such a quorum is not obtainable, or, even if obtainable, a majority vote of a quorum of disinterested Directors so directs, by independent legal counsel in a written opinion, or

(3) By the Subscribers.

SECTION 7.05. *Advancing Expenses.* Expenses (including attorneys' fees) incurred in defending a civil or criminal action, suit or proceeding shall be paid by the Corporation in advance of the final disposition of such action, suit or proceeding, upon authorization by the Board of Directors in a specific case upon receipt of an

undertaking by or on behalf of a Director or Officer to repay such amount unless it shall ultimately be determined that he is entitled to be indemnified by the Corporation as required in this Article or authorized by law and may be paid by the Corporation in advance on behalf of any other authorized representative when authorized by the Board of Directors upon receipt of a similar undertaking.

SECTION 7.06. *Scope of Article.* Each person who shall act as an authorized representative of the Corporation shall be deemed to be doing so in reliance upon such rights of indemnification as are provided in this Article.

The indemnification provided by this Article shall not be deemed exclusive of any other rights to which a person seeking indemnification may be entitled under any agreement, vote of Subscribers or disinterested Directors, statute or otherwise, both as to action in his official capacity and as to action in another capacity while holding such office or position, and shall continue as to a person who has ceased to be an authorized representative of the Corporation and shall inure to the benefit of the heirs and personal representatives of such a person.

ARTICLE VIII

MISCELLANEOUS

SECTION 8.01. *Description of Seal.* The seal of the Corporation shall be circular in form, with the name of the Corporation in the circumference and the words and figures "Incorporated—1938" in the center.

SECTION 8.02. *Conflict of Interest Procedure.* Annually the Officers of the Corporation shall prepare and submit a conflict of interests questionnaire to all of the

Directors, Officers and management employees of the Corporation, who shall respond to the questionnaire by disclosing all of their relevant outside interests, memberships and affiliations.

SECTION 8.03. *Rules of Order.* The rules contained in the then current edition of Roberts' Rules of Order, as revised from time to time, shall govern the Corporation in all cases to which they are applicable and in which they are not inconsistent with these By-Laws and any special rules of order the Corporation may adopt.

ARTICLE IX

FUNDAMENTAL CHANGES; AMENDMENTS

SECTION 9.01. *Subscriber Initiated Action.* Any of the following plans or other corporate action may be proposed by petition of 10% of the Subscribers entitled to vote at an election of Directors, which petition shall be directed to the Board of Directors and filed with the Secretary of the Corporation:

(a) The amendment of the Articles or the adoption, amendment and repeal of these By-Laws.

(b) A plan of sale, lease or exchange of assets under 15 Pa. C. S. § 7930.

(c) A plan of merger, consolidation, division or conversion.

(d) The voluntary dissolution of the Corporation.

SECTION 9.02. *Action Requiring Subscriber Approval.* Except as provided in Section 9.03 of this Article, any plan or other corporate action specified in Section 9.01 of this Article, after having been proposed either by the

Board of Directors or by petition of Subscribers, shall be submitted to a meeting of Subscribers (to be held not more than 60 days after the receipt of a petition, in the case of a meeting of Subscribers to consider and take action on any matter proposed by petition under Section 9.01 of this Article), and shall be deemed adopted by the Corporation when, and only when, approved by the affirmative vote of a majority of Subscribers present in person or by proxy and voting at any regular or special meeting of Subscribers called and held as provided in Article II of these By-Laws, and approved in writing by the Insurance Commissioner and the Governor of the Commonwealth of Pennsylvania.

SECTION 9.03. *Amendments to By-Laws by Board.* The Board of Directors shall have the full authority vested by law in the Board of Directors of a corporation without members to adopt, amend and repeal By-Laws, which action shall require the affirmative vote of two-thirds of the Board of Directors of the Corporation present at any regular or special meeting of Directors at which a quorum is present. Such proposed amendment, repeal or new By-Laws, or a summary thereof, shall be set forth in any notice of such meeting whether regular or special.

Exhibit 3

INTER-PLAN SERVICE BENEFIT BANK

The Inter-Plan Service Benefit Bank is a mechanism through which each Blue Cross Plan (and Health Service, Incorporated) may authorize hospital care benefits for its subscribers when they are admitted as in-patients to Contracting Hospitals of another Blue Cross Plan. The Bank, operated by the Blue Cross Association, serves as coordinator between the Home Plan in which the patient is enrolled as a member, and the Host Plan serving the area in which the hospital is located, in the provision of and payment for covered services.

The amount and kind of care to be provided to a subscriber hospitalized out-of-area is determined by messages exchange between the Host and Home Plans, using the telecommunications system of the Blue Cross Association. However, approval by the Home Plan is specifically limited to the: (1) confirmation of the patient's eligibility for benefits; (2) determination of the number of days during which care may be rendered, according to the benefit days specified in the member's certificate, and prior utilization; (3) designation of the scope of covered ancillary services, as specified in a Host Plan certificate approved for Bank use; and (4) exercise of its option to authorize the Host Plan to provide and pay for service benefits in maternity cases if Host Plan certificates provide only an indemnity allowance for maternity care. Except for the above Home Plan prerogatives, the out-of-area patient is treated as though he were a member of the Host Plan.

The Bank reimburses Host Plans the exact amount of their payments to hospitals and, in turn, Home Plans reimburse the Bank in accordance with a formula which is designed to produce adequate funds to cover both payments to Host Plans and operating costs. The Bank pays Host Plans $3.00 per case to cover claims administration

Exhibit 3

costs, and a like charge is paid to the Bank by Home Plans.

The affairs of the Bank are directed by a Bank Committee appointed by and responsible to the Board of Governors of the Blue Cross Association. Regulations and administrative details essential to the effectiveness of the system, are specifically stated in a Bank Agreement under which each Plan participating in the Bank agrees to comply with established policy and procedure, and commits itself to be responsible for any failure to do so.

Health Service, Incorporated participates in the Bank as a Home Plan only. It becomes involved in Bank cases when a direct-pay subscriber, or member of a National Account group, enrolled by Health Service, Incorporated is hospitalized and responsibility for administration of the Health Service Contract in force is not assigned to and assumed by a particular Blue Cross Plan. When a Plan assumes responsibility for a National Account group, the hospitalization of an enrolled member of the group is reported to that Home Plan and not to Health Service, Incorporated.

In general, the Bank serves as a communications center for the exchange of information between Host and Home Plans which pertain to the provision of hospital care to Blue Cross subscribers, and it serves as a clearinghouse for the money used to pay for such care. Its organization provides the machinery for reviewing and adjudicating any disputes which arise and relate to both these important activities.

LICENSE PROGRAM, APPROVAL PROGRAM, SPECIAL OBLIGATIONS OF MEMBERSHIP AND PLAN PERFORMANCE

This memo and attachments contain a brief explanation of the relationships among the License Program, Approval Program, Special Obligations of Membership and Plan Performance.

License Program

The License Program has a dual purpose: (1) to protect the Blue Cross name and symbol from infringements by third parties; and (2) to assure proper usage of the Blue Cross name and symbol by licensed Blue Cross Plans. With the assumption by BCA of the ownership of the name and mark, effective July 1, 1972, BCA entered into new written license agreements with each Blue Cross Plan which permit the Plan to use the Blue Cross name and symbol within its geographic area so long as it adheres to license requirements of general application. These requirements are set forth in Attachment "1." Such requirements are the same as those contained in the prior license agreements between AHA and Plans. The license requirements may be revised only upon the affirmative vote of three-fourths (¾) of the Plans and three-fourths (¾) of the total weighted vote of all Plans.

In addition, licensed Plans are required to display the name and mark in such form, style and manner as shall be specifically prescribed by BCA in regulations of general application to prevent the impairment of the distinctiveness of the name and mark and the good will pertaining thereto. The Plan is also required to display such legends, markings and notices as BCA may request in order to give appropriate notice of any trademark or

trade name. Such license regulations to prevent impairment of distinctiveness may be changed upon a two-third (⅔) vote of the whole Board preceded by at least sixty (60) days prior written notice to regular Member Blue Cross Plans of any proposed changes.

Further, the Plan is required to submit data annually to BCA or at other times upon the written request of BCA which demonstrates its compliance with the requirements of the License Agreement.

The license of any Plan may not be terminated except for failure to meet the license requirements of general application, failure to comply with the regulations of general application with regard to the display of the marks and/or failure to submit required data.

The License Program is administered by BCA's Legal and Corporate Division on the basis of data collected through the Approval Program, both at the time of submission of the reapproval application and in the course of Plan visitations.

Approval Program

The Approval Program dates back to 1933. Its purpose was to assure that standards of performance were maintained to protect the interests of the public and of hospitals. During AHA's administration, standards were strengthened and clarified on a number of occasions. The administration of this program was likewise assumed by BCA, effective July 1, 1972. A copy of the Approval Program as revised is attached to this memo. Only Plans that are licensed are eligible to be approved. Only Plans which are approved by BCA are awarded an approval certificate and are entitled to refer to themselves as "Approved" Blue Cross Plans. Approval standards are broad, general principles which equate roughly with rules

of "good citizenship" for Blue Cross Plans. While the approval standards contain all of the license requirements of general application, they are more comprehensive and deal with additional matters such as financial responsibility, not included among the license requirements.

Plans may not be approved and yet be licensed. Approval is a condition of eligibility for initial and continued membership in the Association.

Approval is granted annually by the BCA Board on the basis of data regularly submitted by Plans. Plans are visited on a three year cycle for the purpose of reviewing supplementary information and monitoring Plan compliance with license regulations. The Approval Program, like the License Program, is administered by the Legal and Corporate Division. The Board appointed Plan Approval Committee has two functions: (1) to make recommendations to the Board with regard to Plan approval applications; and (2) to make recommendations for changes in the approval standards. At the board's request, the Committee has devoted itself first to developing a recommended change in Approval Standard #1 concerning majority public representation; its next effort will be to make recommendations with regard to Approval Standard #4 on financial responsibility; these efforts to be followed by a general review and recommendations with regard to the remaining standards and any proposed additions thereto.

Upon the assumption by BCA of the administration of the Approval Program, Member Plans voted to require compliance with the standards of the Approval Program as a special obligation of membership. As such, any changes in the approval standards require approval of the Board and the affirmative two-thirds (⅔) weighted vote of Member Plans.

SPECIAL OBLIGATIONS OF MEMBERSHIP

Eligibility for Regular Membership in the Association (Article III, Section I) requires that "Each Blue Cross Plan . . . has been and continues to be formally approved by the Blue Cross Association. . . ." Each Regular Member is obligated to pay monthly dues and marketing service charges (Article III, Section 2). Plans must also use their best efforts to cooperate and support BCA in the achievement of its obligations and purposes and to abide by the intent and spirit of the Association's By-Laws (Article III, Section 3 (g)).

Special obligations are set forth in Article III, Section 3. Originally, subparagraph (a) bound Plans to participate in the Service Benefit Bank Agreement, Transfer Agreement, the Local Benefit Agreement for National Accounts and the National Advertising Program. In order to avoid the necessity of reprinting the By-Laws at times when other obligations might be added, the Plans adopted an amendment to the By-Laws on July 14, 1971 whereby other programs and procedures as may be approved by the Board from time to time and adopted by the affirmative vote of the Regular Members entitled to ⅔ (two-thirds) of the weighted votes could be made obligations of membership. In this fashion, there was added an obligation of membership, effective October 1, 1971, requiring each Regular Member to adopt and implement a conflict of interest policy and procedure following BCA guidelines contained in memorandum dated January 15, 1971. Subsequently, in connection with the transfer of the licensure and approval programs from AHA to BCA, the Members added another special obligation of membership requiring compliance with the standards of the present "Approval Program for Blue Cross Plans" and as it may be amended from time to time on approval of the Board and the affirmative ⅔ (two-thirds) weighted vote of Member Plans.

Over the years, in actions pursuant to the provisions of subparagraphs (b), (c), and (d), the Board of Governors has approved various benefit patterns embodied in the National Account Contract and numerous riders, the last one dealing with "abortion" benefits. In the same manner, the provision of service benefits for out-of-hospital prescription drugs was accomplished (June 23, 1967). Similarly, the Board has approved the equalization document and various amendments.

PLAN PERFORMANCE PROGRAM

A summary of the more recent history of BCA's Plan Performance activity may be helpful in understanding the performance function itself and its relationship to the License and Approval Programs.

At the August 23, 1964 Board of Governors meeting, the Board supported the re-creation of the Plan Performance Review function and the establishment of a seven man Plan Performance Review Committee. No conflict with or duplication of AHA efforts was deemed to be involved in AHA's handling of the Approval Program. At the outset, the proposed review program had "at least three basic purposes: (1) through periodic review to identify problems for individual Plans which would affect adversely other Plans and to provide corrective assistance; (2) to assist Plans in maintaining their AHA approved status; and (3) to review membership status in the BCA with particular reference to the special obligations of membership."

At the Executive Committee meeting of August 20, 1970, in dealing with the problem of diversification, it was voted that "present or contemplated diversification activity be taken into account as part of Plan Performance Reviews." The resolution contemplated that "consultation and advice will be available not only through contact with

BCA staff apart from and at the time of a Plan Performance Review, but also directly through the Executive Committee."

At the Executive Committee meeting of October 19-20, 1970, among the functions of the committee described was "to review methodolgy of Plan Reviews, assist staff in making the Plan Reviews more meaningful and of maximum assistance to the Plans, evaluate proposed standards of Plan Performance and make recommendations for adoption of such standards by the Board of Governors, and develop concepts of technical assistance."

At the January 23, 1971 BCA Board meeting, a strong consensus was expressed in favor of full support and endorsement for the continued growth and development of the Plan Performance Review function as a "comprehensive, objective and searching inquiry into all areas of Plan management and operation."

At the March 12, 1971 Special Meeting of the Board of Governors, among the policy statements adopted were the following:

> 3. Member Plans were required to have a conflict of interest policy and procedures following Board guidelines as a special obligation of membership. The Board directed the BCA Performance Review staff to implement this policy as an ongoing part of its Plan Performance Program;
>
> 4. The Board approved a slight modification of Section 4—Visitation—of the BCA By-laws;
>
> 5. Reaffirmed its support of rigorous Plan Performance Review program for management, fiscal status, systems, national accounts and ad hoc purposes —for the development of Performance Standards and technical assistance. With regard to Performance Standards, the Board saw the need to focus on "im-

proved subscriber services, including such areas as claims payment, notices of hospital admissions, ID cards and the Inter-Plan Service Bank";

8. The Board reaffirmed its support for the March 31, 1970 Statement on Diversification which included a role for Plan Performance.

At the June 9-10, 1971 Board meeting, the recommendations of the Plan Performance Committee were endorsed and the Committee authorized "to establish and approve standards of Plan Performance, including the updating and modification of such standards in the light of experience; provided, however, that the Board be kept informed on a continuing basis. . ."

At the February 5, 1972 Board meeting, the Board endorsed and approved management recommendations regarding the review and monitoring of BCA performance and the relationship to the committee now known as the Standing Committee on Operating Plan and Budget.

The foregoing indicates that the Plan Performance Committee is ongoing and is responsible for monitoring the performance of the BCA and Blue Cross Plans, and, in conformance with the 1964 Board action, was given the responsibility to identify problems for individual Plans which would affect adversely other Plans and to provide corrective assistance; to assist Plans in maintaining their approved status (now under the program as administered by BCA); review membership status with reference to special obligations of membership (again to assist Plans in maintaining compliance with the special obligations of membership). With regard to the latter, it should be pointed out that some special obligations of membership are now included in the interpretations to Approval Standards #1 and #7. In addition, the Plan Performance Committee monitors and reviews specific problems as

identified by the Board of Governors and the committee and makes recommendations for their resolution and improvement, when appropriate and necessary (e.g., diversification and conflict of interest matters).

Liaison between the two BCA divisions involved with licensure, approval and Plan performance (i.e., Legal and Corporate and Administrative Services) and between the various committees involved (i.e., the Executive Committee, the Standing Committee, the Plan Performance and Plan Approval Committee) has been maintained. In line with the practice commenced in 1964, the Senior Director, Approval and Licensure Programs, makes available immediately, a copy of the completed Plan reapproval application. In addition, (after Plan visits) he alerts Administrative Services to matters which merit consideration for Plan assistance. Conversely, the Administrative Services team (after visits) alerts the Legal and Corporate Division to matters which might affect a Plan's approval status. Both divisions cooperate in the handling of matters involving conflict of interest, and particularly diversification, for which the Executive Committee has retained prime monitoring responsibility.

LICENSE REQUIREMENTS OF GENERAL APPLICATION—
BCA LICENSE AGREEMENT

The Plan shall, as a condition to the grant and to the continuance of its licensing hereunder, comply with the following requirements:

(a) The corporate body of each Plan shall be representative of the community and hospitals served by such Plan.

(b) Trustees, board and corporation members of each Plan shall receive no compensation for services as such.

Exhibit 4A

(c) No portion of the earnings remaining after payment of the cost of operation shall inure to the benefit of any individual.

(d) Every qualified general hospital in the area served by the Plan shall have reasonable opportunity to become a contracting hospital.

(e) Subscribers shall have free choice among contracting hospitals.

(f) Service benefits, as distinguished from wholly cash indemnity benefits, and as determined in good faith by the Plan, shall be provided through contract between the Plan and its contracting hospitals.

(g) Provision shall be made for benefits in qualified noncontracting hospitals.

(h) The finances of every Plan shall be kept separate from those of any hospital.

(i) No employee of a Plan shall be paid principally by commission or on a production fee basis.

(j) The foregoing requirements shall apply except to such extent as may be prohibited by law.

Exhibit 4B

APPROVAL PROGRAM FOR BLUE CROSS PLANS

This booklet describes the official Approval Program for Blue Cross Plans. It supersedes all previously published statements.

As early as 1933, the concept of Prepayment for Hospital Care was endorsed and within several years thereafter a set of Approval Standards for Non-Profit Hospital Service Plans was adopted. The Approval Program has been in continuous operation ever since. During this period, on several occasions, the Approval Standards and their interpretations were strengthened and clarified.

The purpose of the Approval Program for Blue Cross Plans is to assure that standards of Performance are maintained to protect the interests of the public.

The interests of the public are protected by standards which require a Plan—to include representatives of the public and hospitals on its policy-making governing board; to promote enrollment; to provide benefits which substantially cover the costs of hospital services; to achieve and maintain financial stability; to pay out at least 85 per cent of subscriber income in the form of subscriber services; to report to the public concerning its operations and its programs; to operate in such a manner that none of its net earnings shall inure to the benefit of any individual, and to meet certain licensing requirements which permit the Plan to use the Blue Cross symbol and name which are registered by the Blue Cross Association.

Only those Blue Cross Plans which are approved by the Blue Cross Association have the right to use the words "Approved by the Blue Cross Association."

General Principles

1. Approval of the Blue Cross Association and the words "Approved by the Blue Cross Association" shall be

determined by a Plan's adherence to the "standards" set forth in the following section.

2. The Interest and Responsibility of contracting hospitals, that is, hospitals guaranteeing service, make it desirable that in addition to representatives of the general public, the Plan's governing board shall include representatives of such hospitals. It is also desirable that the medical profession be represented on the Plan's board.

3. All Hospitals in Each Enrollment Area that are qualified and equipped to provide the services in the Plan's subscriber certificate should have an opportunity to contract to provide these benefits. At least a majority of these hospitals should so contract. Equitable arrangements should be made for provision of benefits in non-contracting hospitals.

4. No Plan Should Be Given Original Approval whose territory does not comprise sufficient area and population to provide adequate spread of risk and efficient and economical management, with an adequate number of hospitals to assure service to subscribers.

5. Plans Should Arrange for Service Benefits to hospitals, rather than provide cash allowances for the purchase of hospital care.

Approval Standards for Blue Cross Plans Within the United States

1. Organizational Structure

A Plan's corporate and administrative structure shall be consistent with its scope and functions, and shall be governed by a board composed of representatives of the public and providers of service.

Interpretation:

A. At least one-third of the members of the Plan's governing board shall be representative of the public and at least one-third shall be representative of the contracting hospitals.

B. The interests of any officer, director or trustee of a Plan shall not be in conflict with the interests of the Plan.

2. Authority to Operate

A Plan shall operate as a voluntary, non-profit, community service organization.

Interpretation:

A. A Plan shall have defined community service objectives which it implements in its operations.

B. A Plan shall operate in conformance with its legal authority.

C. Trustees or board members of a Plan shall receive no renumeration for such service, nor shall any part of the net earnings of a Plan inure to the benefit of any individual.

3. Benefits to Members

A Plan shall provide its members with benefits which substantially cover the costs of hospital services.

Interpretation:

A. A Plan shall cover, on behalf of all member patients, an average of not less than 75 per cent of the total amount billed for usual and customary hospital services rendered on an inpatient basis in mul-

tiple bed accommodations in contracting hospitals. There shall also be some provision for outpatient coverage.

B. A Plan shall have provided as subscriber benefits, a minimum average of 85 per cent of its earned subscriber income during the three-year period immediately preceding the current approval review.

C. A Plan's benefits shall be increased to keep pace with the development of expanded services in contracting hospitals, and to work toward comprehensiveness of benefits.

4. Financial Responsibility

A Plan shall maintain a financial condition that adequately protects subscriber interests as evidenced by reports which include a full statement of all direct and contingent liabilities as presented in an independent annual audit.

A Plan's assets shall exceed its liabilities in order to qualify for approval.

Interpretation:

A Plan's reserves shall be deemed minimally adequate if they meet one of the three following criteria:

A. They are sufficient to meet hospital and operating expenses for a period of at least three months; or

B. They have been increased by the addition of at least three per cent of gross income during the preceding twelve-month period; or

C. They will be increased or not drastically reduced during the forthcoming twelve-month period, based on a projection of next year's operations.

5. Relationship With Individual Hospitals

A Plan shall have written agreements with at least 75 per cent of non-federal short-term hospitals registered by the American Hospital Association containing at least 75 per cent of these hospitals' beds in the Plan's service area, and the agreements shall include:

A definition of the responsibility of the Plan to the hospital with respect to frequency of hospital reimbursement.

A definition of the method of hospital payment.

A definition of the responsibility of the contracting hospital to the Plan with respect to servicing and guaranteeing service to members holding contracts for which the Plan assumes responsibility and the hospital's responsibility for the prudent use of its facilities and services.

A definition of the rights of the Plan and its contracting hospitals regarding the right of inspection of the records by the other party to the contract and a statement of the rights of either party to cancel or amend the contract.

Interpretation:

A Plan may adopt reasonable standards governing the acceptability of hospitals as contracting hospitals. In the event a Plan's standards of acceptability are more stringent than the American Hospital Association standards for registration, a lesser percentage than 75 per cent may be used by the Blue Cross Association to determine compliance with this standard.

6. Accounting and Statistical Records

A Plan shall maintain such accounting and statistical records as may be reasonably required by the Board of Governors of the Blue Cross Association and shall submit such reports on the form and in the manner so prescribed.

Exhibit 4B

7. Interplan Cooperation

A Plan shall participate in national programs, generally accepted by Plans.

Interpretation:

The continuing availability of hospital service benefits to large segments of the public without geographic restriction requires effective cooperation among Plans and their contracting hospitals.

8. Enrollment

A Plan's enrollment objectives shall be determined and results shall be evaluated at least annually.

Interpretation:

A. A Plan shall provide group and non-group enrollment opportunities to the people in its service area at least annually.

B. Responsibility for promotion and enrollment shall be vested in the salaried management of the Plan. An independent sales agency shall not be given responsibility for promotion and administration.

9. Public Information

A Plan shall conduct a continuing informational program to explain its functions, services, financing, and responsibilities to the public.

10. Relationship With Organized Groups of Hospitals

A Plan shall maintain close liaison with organized groups of hospitals in its area.

Exhibit 4B

Interpretation:

A. The Plan representatives and the state or local hospital association representatives shall meet at least semiannually to discuss matters of mutual interest.

B. A Plan shall participate in programs sponsored by organized groups of hospitals.

C. A Plan shall regularly exchange with organized groups of hospitals, statistical, financial or any other information of mutual interest.

11. Licensed by the Blue Cross Association

A Plan shall be a licensee in good standing under an agreement with the Blue Cross Association which attests to the Plan's compliance with the standards for such licensure and permits it to use the Blue Cross symbol and name.

Failure to Meet Approval Standards

If a Plan fails to meet the provisions of one or more of the foregoing standards, the Plan Approval Committee may recommend to the Board of Governors of the Blue Cross Association that such Plan's approval be terminated. If a Plan fails (a) to furnish such information in support of its application as may reasonably be required, or (b) to comply with the foregoing standards, all within such period as the Board of Governors may deem reasonable, the Board of Governors may terminate its approval.

If a Plan's failure to comply with one or more of these standards results in its being notified that approval is to be withdrawn, it shall have the right, upon request to the Board of Governors of the Blue Cross Association, to present evidence of the extent to which circumstances prevent compliance.

Exhibit 4B

APPROVAL REQUIREMENTS FOR ORGANIZATIONS
OPERATING NON-PROFIT BLUE CROSS PLANS
OUTSIDE THE UNITED STATES

1. The governing board shall contain representation of the public and of hospitals from the area served.

2. No member of the governing board shall receive compensation for service as such.

3. No portion of the earnings remaining after the cost of administration has been satisfied shall inure to the benefit of any individual.

4. Subscribers shall have free choice of physician and hospital.

5. The Plan shall make available to the public benefits which shall cover at least 75 per cent of that portion of hospital expense which the Plan acknowledges it is in business to prepay.

6. Provision shall be made for benefits in out-of-area cases.

7. Finances shall not be comingled with those of any hospital.

8. No employee shall receive more than half of his compensation through commissions or on a production-fee basis.

9. Reports as to fiscal condition and membership status and such other reports as may reasonably be required shall be furnished to the Blue Cross Association upon request.

10. The Plan shall be a licensee in good standing to use the Blue Cross symbol and the words "Blue Cross."

11. The foregoing requirements shall apply except as they may be prohibited by law.

Exhibit 4B

SPECIAL OBLIGATIONS OF MEMBERSHIP

Eligibility for Regular Membership in the Association (Article III, Section I) requires that "Each Blue Cross Plan . . . has been and continues to be formally approved by the Blue Cross Association . . ." Each Regular Member is obligated to pay monthly dues and marketing service charges (Article III, Section 2). Plans must also use their best efforts to cooperate and support BCA in the achievement of its obligations and purposes and to abide by the intent and spirit of the Association's By-Laws (Article III, Section 3 (g)).

Special obligations are set forth in Article III, Section 3. Originally, subparagraph (a) bound Plans to participate in the Service Benefit Bank Agreement, Transfer Agreement, the Local Benefit Agreement for National Accounts and the National Advertising Program. In order to avoid the necessity of reprinting the By-Laws at times when other obligations might be added, the Plans adopted an amendment to the By-Laws on July 14, 1971 whereby other programs and procedures as may be approved by the Board from time to time and adopted by the affirmative vote of the Regular Members entitled to ⅔ (two-thirds) of the weighted votes could be made obligations of membership. In this fashion, there was added an obligation of membership, effective October 1, 1971, requiring each Regular Member to adopt and implement a conflict of interest policy and procedure following BCA guidelines contained in memorandum dated January 15, 1971. Subsequently, in connection with the transfer of the licensure and approval programs from AHA to BCA, the Members added another special obligation of membership requiring compliance with the standards of the present "Approval Program for Blue Cross Plans" and as it may be amended from time to time on approval of the Board and the affirmative ⅔ (two-thirds) weighted vote of Member Plans.

Exhibit 4B

Over the years, in actions pursuant to the provisions of subparagraphs (b), (c), and (d), the Board of Governors has approved various benefit patterns embodied in the National Account Contract and numerous riders, the last one dealing with "abortion" benefits. In the same manner, the provision of service benefits for out-of-hospital prescription drugs was accomplished (June 23, 1967). Similarly, the Board has approved the equalization document and various amendments.

REQUIREMENTS FOR AFFILIATE MEMBERSHIP

(By-Laws Article V. Sec. 1)

1. The non-profit organization shall provide health service benefits.

2. The organization's governing board shall contain representatives of the public and the providers from the area served and no board member shall receive compensation for service as such.

3. The earnings of the organization shall not enure to the benefit of any individual.

4. The organization shall demonstrate a continuing interest in the policies of the Blue Cross Association.

5. The organization shall have made significant contributions to the field of prepaid health care.

6. The organization shall not use the registered service marks, the term "Blue Cross" and the design of a Blue Cross without the prior written permission of or written license from the Blue Cross Association.

Exhibit 6A

CO-PAY PREFERRED COMPREHENSIVE SUBSCRIPTION AGREEMENT

ARTICLE I. IN-PATIENT BENEFITS

Blue Cross will provide to each Subscriber In-Patient Benefits as follows:

Section 1. Days Available

All benefits provided under this Agreement for in-patients shall be available to each Subscriber for not more than the number of days specified below for each benefit period, based on the Subscriber's classification and length of continuous membership in Blue Cross at the time of admission. Successive admissions for purposes of this Agreement shall be considered to constitute a single benefit period if discharge from and subsequent admission to any hospital or extended care facility occur within a 90-day period, except when otherwise specified.

In computing the number of days of benefits, the day of admission, but not the day of discharge, shall be counted; except, however, if the Subscriber is admitted and discharged on the same day, it shall be counted as one day.

A. *Hospital Days Available Per Benefit Period*

(1) General Conditions—the following number of days are available for conditions other than those designated in subparagraphs A(2) through A(5) below:

Group Subscribers	*Length of Membership*	*Non-Group Subscribers*
50 days	First Year	30 days
60 days	Second Year	40 days
80 days	Third Year	50 days
100 days	Fourth Year	60 days
120 days	Fifth Year and Thereafter	70 days

(2) Pregnancy, including any disease, injury or condition arising therefrom—up to 6 days, except in cases of:

(a) Caesarian section or premature termination of pregnancy not resulting in childbirth—up to 10 days; or

(b) Ectopic pregnancy, eclampsia, post partum hemorrhage, retained secundines and such other severe complications of pregnancy as may be determined by Blue Cross—up to the number of days to which the Subscriber is then entitled under Subparagraph A(1) above.

(3) Mental or Nervous Disorders, Alcoholism and Drug Addiction or any combination thereof—up to 30 of the days to which the Subscriber is otherwise entitled as set forth in subparagraph A(1) above. Readmission within 365 days of the last discharge for any of these conditions shall be considered to be in the same benefit period.

(4) Removal of Tonsils and/or Adenoids—1 day for Subscribers under 12 years of age and 2 days for all other Subscribers.

(5) Dental Surgery, except when required because of accidental injury—1 day for Subscribers under 12 years of age and 2 days for all other Subscribers.

Days available under this Agreement shall be allowed only during uninterrupted stays in a Hospital or Extended Care Facility. Benefits shall not be provided hereunder: (1) during the absence of a Subscriber who interrupts his stay and remains absent past midnight of the day on which the interruption occurred; (2) after the discharge hour when a Subscriber has been advised by his attending physician prior to the discharge hour of the

Hospital or Extended Care Facility that further in-patient care is not required.

Section 2. Benefits in Blue Cross Member Hospitals

The following benefits when provided to the Subscriber as an in-patient in Blue Cross Member Hospitals are subject to the payment by the Subscriber of $10.00 per day toward the hospital's charges for the covered services for the first 10 days of hospitalization during each benefit period.

A. Accommodations, including bed, board, general nursing care and such other services as are covered by the hospital's regular charges for such accommodations, subject to the provisions of paragraph C of this Section 2, as follows:

(1) Semi-Private accommodations, designated as such by the hospital and containing not more than four beds, or private accommodations designated by Blue Cross as semi-private for purposes of this Agreement in hospitals having primarily single accommodations; or

(2) Private accommodations, designated as such by the hospital and containing not more than one bed, as medically necessary when the Subscribers' condition requires him to be isolated for his own health or that of other patients and as ordered by the attending physician; or

(3) A private room allowance, when the Subscriber occupies private accommodations in the absence of such medical necessity, equal to the hospital's most prevalent charge for semi-private accommodations.

Exhibit 6A

B. All additional services usually provided and billed for by hospitals (except ambulance and personal convenience items) required solely for the institution and/or the application of therapy for the condition(s) for which hospitalization is required, including but not being limited to:

(1) Special meals and dietary services; use of operating, delivery, recovery, cystoscopic, treatment and other specialty service rooms and equipment and supplies; use of intensive care, cardiac care and other such specialty service units; casts; surgical dressings and supplies; devices or appliances surgically inserted within the body; oxygen and oxygen therapy; administration of blood and blood plasma, including the processing of blood from donors but excluding the blood or blood plasma; anesthetic supplies and the use of anesthetic equipment; anesthesia when administered by a hospital employee; physical therapy when administered by a hospital employee; radiation therapy; and all drugs, medications and combinations thereof (including intravenous injections and solutions) for use while in the hospital and which are released for general use and are commercially available to hospitals; and

(2) Indemnity for the reasonable and customary expense incurred for certain medical services when incident to hospitalization, including laboratory, electrocardiographic, electroencephalographic and x-ray examinations, metabolism tests, anesthesia and physical therapy rendered by physicians to Subscribers in accordance with the regulations of the hospital in which the Subscriber is hospitalized and further in accordance with the arrangements existing at the time of such hospitalization between the hospital and

Exhibit 6A

the physician or physicians rendering such medical services, provided, however, that the indemnity for anesthesia shall not exceed $10.00 for any one admission.

(3) Transplant Services—When the Subscriber is the recipient of transplanted organs, bones, etc., benefits of this Agreement are provided for those services to the Subscriber which are directly and specifically related to the transplantation. Benefits are also provided for examinations of such transplanted organs, bones, etc. and the processing of blood provided to a Subscriber. No benefits are provided for the hospitalization of donors, or for blood, organs, bones, etc. provided by donors.

(4) Newborn Care—When pregnancy benefits are provided for the Subscriber, the newborn child of the Subscriber shall be an eligible Subscriber at birth and shall be entitled to benefits for (a) treatment of illness, injury or congenital defects, (b) incubator or isolette care, (c) treatment of prematurity or postmaturity, (d) circumcision, and (e) nursery care.

(5) Ambulant Care—When the Subscriber is admitted to a section of a hospital providing ambulatory, convalescent, or rehabilitative care, or is transferred to such section after first having been admitted for needed medical or surgical treatment to the acute section of the same or another hospital, the total number of days for which benefits would otherwise be available under this Agreement shall not exceed the average number of days of service, as determined by Blue Cross, for treatment of the particular diagnosis or condition.

C. Diagnostic Study—Benefits for services of the character referred to in paragraph B of Section 2 above are available when hospitalization in a Member Hospital is for "Diagnostic Study." Such benefits shall not include accommodations or those services covered by the hospital's regular charges for accommodations as provided in paragraph A of Section 2 above. "Diagnostic Study" means cases hospitalized principally for diagnostic or medical observation required for the diagnosis of a definite symptomatic condition of disease or injury (even though therapy directed toward the relief of symptoms may be rendered) as determined by Blue Cross.

Section 3. Benefits in Contracting Hospitals of any other Blue Cross Plan

Benefits will be provided for in-patient hospital services furnished by a contracting hospital of any other Blue Cross Plan in accordance with the agreement which Blue Cross has with the Inter-Plan Service Benefit Bank for the number of days then available under Article I, Section 1 of this Agreement, but in no case shall such benefits be less than the benefits provided hereunder in a Non-Member Hospital.

Section 4. Benefits in Non-Member Hospitals

Upon receipt of a valid bill, itemized as required by Blue Cross, for the Subscriber's hospitalization as an in-patient in a Non-Member Hospital, Blue Cross will pay to such Subscriber an allowance of up to $50.00 per day for the first day and up to $25.00 per day for each day thereafter toward the hospital's regular charges, except that:

A. In cases when a newborn child remains in the nursery after the mother has been discharged, such child

shall be entitled to an allowance of up to $10.00 per day toward the charges for nursery care.

B. In cases hospitalized in school infirmaries and hospitals directly or indirectly operated by any local or state governmental body or agency, an allowance of up to $5.00 per day toward such infirmary's or hospital's regular charges.

Section 5. Benefits in Member and Non-Member Extended Care Facilities

Benefits shall be available to the Subscriber for post-hospital cases requiring skilled nursing care for the continued treatment of an illness or injury which required not less than 3 days of hospitalization, provided that the Subscriber is admitted to an Extended Care Facility within 14 days following the termination of such hospitalization. For the purpose of determining the number of days to which the Subscriber is entitled under subparagraph A(1) of this Article I, each day in an Extended Care Facility shall be counted as one half day. The benefits provided to the Subscriber in such cases shall be as follows:

A. Member Extended Care Facilities

All services provided under Section 2 paragraph A and subparagraph B(1) of this Article I which are usually provided and billed for by the Extended Care Facility (except ambulance and personal convenience items);

B. Non-Member Extended Care Facilities

Upon receipt of a valid bill, itemized as required by Blue Cross for Subscriber's care in a Non-Member Extended Care Facility, Blue Cross will pay to such Subscriber an allowance of up to $12.00 per day toward the Non-Member Extended Care Facility's regular charges.

Exhibit 6A

ARTICLE II. OUT-PATIENT BENEFITS

Blue Cross will provide to each Subscriber Out-Patient Benefits as follows:

Section 1. Benefits in Blue Cross Member Hospitals

The following benefits when provided to the Subscriber as an out-patient of a Blue Cross Member Hospital are subject to the payment by the Subscriber of a $10.00 deductible toward the hospital's charges for such services:

A. All hospital services and/or the certain medical services incident to hospitalization provided in Article 1 Section 2B(1) and (2) required for treatment of illness or injury as limited herein:

(1) Accidental Injury—treatment rendered within 48 hours of the accident.

(2) Medical Emergency — treatment rendered within 48 hours of the onset of the emergency. "Medical Emergency" means a sudden and unexpected onset of a condition with severe symptoms requiring immediate medical care and includes heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsion or other such acute medical conditions as determined to be medical emergencies by Blue Cross.

(3) Surgical Operation—services required for out-patient surgery.

(4) Radiation Therapy—use of x-ray, radium, cobalt and other radioactive substances, provided, however, that the deductible shall be applicable only once during any period of four consecutive days.

B. Diagnostic Tests and Procedures when medically necessary for the diagnosis of a definite symptomatic con-

Exhibit 6A

dition of disease or injury—including radiation, basal metabolism, clinical laboratory and pulmonary function examinations; electrocardiograms and electroencephalograms; pathological examinations of tissue removed by resection or biopsy (excluding smear techniques); and such other diagnostic tests and procedures as may be designated by Blue Cross, provided, however, when any such tests and procedures are performed within any period of four consecutive days the Subscriber shall be responsible for only one deductible.

Section 2. Benefits in Contracting Hospitals of any Other Blue Cross Plan and Non-Member Hospitals

For accidental injury, medical emergency, surgical operation and radiation therapy as specified in paragraph A, of Section 1, of this Article II, Blue Cross will pay to the Subscriber an allowance of up to $10.00.

ARTICLE III. TERMS AND CONDITIONS

Section 1. Waiting Periods and Pregnancy Provisions

A. Pre-existing Conditions—Benefits for pre-existing conditions will be available to each Subscriber only after the expiration of 12 consecutive months following the effective date of this or any prior Blue Cross Agreement providing uninterrupted coverage for the Subscriber. "Pre-Existing Condition" means a condition, disease, illness or injury which existed or had its beginning to any degree, whether diagnosed or not, prior to the effective date of coverage. Benefits shall not be provided for any condition excluded from coverage by the terms of this Agreement, or by rider, even after the expiration of the 12 month period.

B. Removal of Tonsils or Adenoids—Benefits will be available to each Non-Group Subscriber only after the

expiration of 6 consecutive months following the effective date of this or any prior Blue Cross Agreement providing uninterrupted coverage for the Subscriber.

C. Pregnancy Provisions—Benefits for pregnancy will be allowed to an Applicant Subscriber or spouse enrolled under a family Subscription Agreement only after the expiration of 8 consecutive months following the effective date of such Agreement providing uninterrupted coverage for the Subscriber, except that such waiting period shall not apply in case of ectopic pregnancy and premature terminations of pregnancy not resulting in childbirth.

When there has been a change in the Subscriber's enrollment status, pregnancy benefits will be allowed on the basis of the coverage held at the time of conception.

Section 2. Exclusions

Benefits shall not be provided under this Agreement for:

A. Services, facilities or supplies (1) covered by programs created by the laws of the United States, any state or any political subdivision, (2) furnished in a federal institution, (3) in connection with any disease contracted or injury sustained during military service or war, declared or undeclared, or any act of war, (4) for any occupational condition, ailment, or injury arising out of and in the course of employment, (5) to the extent that the cost thereof may be recoverable by or on behalf of the Subscriber in any action at law or in compromise or settlement of any claim, against any party, other than an insurer of the Subscriber, (6) furnished without charge to the Subscriber.

B. Services, facilities or supplies (1) not ordered by the attending physician, (2) not reasonable and necessary

for the diagnosis or treatment of illness, injury or restoration of physiological functions (except that this exclusion shall not apply to pregnancy care, circumcision, procedures for the prevention or interruption of pregnancy and cosmetic procedures related to injury sustained while a Subscriber), (3) for the care of gums, teeth or the extraction of teeth other than impacted teeth unless such care consists of surgery for the treatment of diseases or injuries of the jaw or any structure contiguous to the jaw or for the treatment of fractures and/or dislocations of the jaw or any facial bone or (4) for custodial and domiciliary care, research studies, screening examinations, check-ups, rest cures, convalescent care, weight reduction, routine physical or pre-marital examinations, or diagnostic services or examinations in connection with pregnancy.

C. Fees of any physician, surgeon, private nurse or other professional persons or their board or other medical services except as set forth herein.

D. In Non-Member Hospitals and Contracting Hospitals of other Blue Cross Plans, in-patient cases principally for diagnosis, diagnostic study or medical observation (even though therapy directed toward the relief of symptoms may be rendered) when the necessary care can properly be provided on an out-patient basis as determined by Blue Cross and the condition of the Subscriber or the nature of the procedure does not necessitate that the Subscriber be admitted as an in-patient.

E. If Blue Cross should pay for any excluded services or supplies through inadvertence or error, the Subscriber shall reimburse Blue Cross for such payments.

Section 3. Assignment

This Agreement and the benefits hereunder are personal to the Subscriber and are not assignable by the

Subscriber in whole or in part to any person, hospital or other entity.

Section 4. Subrogation

In the event any hospital service or benefit is provided or any payment is made to a Subscriber under this Agreement, Blue Cross shall be subrogated and succeed to the Subscriber's rights of recovery therefor against any person or organization except against insurers on policies of insurance issued to and in the name of the Subscriber, and the Subscriber shall execute and deliver such instruments and take such other action as Blue Cross may require to secure such rights. The Subscriber shall do nothing to prejudice the rights given Blue Cross by this section.

Section 5. Payment of Benefits and Indemnity

A. The Subscriber, the Member Hospital, Member Extended Care Facility, and physician rendering services indemnified for herein may submit bills directly to Blue Cross to the extent that benefits and indemnity are payable within the terms and conditions of this Agreement:

(1) Blue Cross will compensate Member Hospitals and Member Extended Care Facilities periodically in accordance with the contracts entered into between such Member Hospitals or Member Extended Care Facilities and Blue Cross.

(2) Blue Cross will indemnify the Subscriber for the reasonable and customary expenses incurred for the certain medical services rendered when incident to hospitalization as described and limited herein, provided that if the bills for such service or services are submitted by the physician directly to the Subscriber, the Subscriber shall forward such bills directly to Blue Cross for payment. If, however, the bills for such services are included in the hospital bill of a Subscriber, payment therefor shall be made to the hospital, subject, however, to the then existing arrangements between the hospital and physician rendering such services.

B. That portion of any bill in excess of the limits of this Agreement is not the obligation of Blue Cross. It is the purpose of this Agreement to provide payment to hospitals and physicians for hospital services and the certain medical services rendered when incident to hospitalization within the limits of this Agreement, as indemnity for reasonable and customary expenses incurred by the Subscriber for such services, but no payment is to be made directly to any Subscriber for such services rendered by any Member Hospital.

Section 6. Termination

A. Modification or Termination—This Agreement may be modified or terminated at any time by the Blue Cross at its option upon: (1) non-payment of charges as required; (2) failure or refusal after 30 days' written notice to comply with rate or benefit changes applicable to this Agreement; or (3) failure or refusal of the Subscriber after 30 days' written notice to transfer to the Blue Cross Plan serving the area to which he has changed residence.

B. Termination by Incorrect Information or Misrepresentation—As a material inducement for the issuance of this Agreement, it is represented by the Applicant that all statements made and information shown in the Application are true and complete and are correctly recorded and noted in the Application. Any misrepresentation therein is material to the risk and will, at the option of the Blue Cross, subject to the provisions of subparagraph E hereof,

render this Agreement void from inception and will forfeit any charges theretofor paid to the extent of any liability incurred by Blue Cross.

C. Termination Without Claim Prejudice—When this Agreement is terminated, except for termination by incorrect information or misrepresentation, and a Subscriber is receiving in-patient benefits on the date of such termination, benefits will continue to be provided only to the date of discharge or expiration of eligible benefit days, whichever is earlier.

D. Renewability of Agreements Issued on a Non-Group Basis—When an Agreement is issued on a Non-Group basis, it shall be renewable at the option of the Applicant unless sufficient notice in writing of non-renewal is mailed to the Applicant by Blue Cross, addressed to the last address recorded with Blue Cross. "Sufficient Notice" is defined as follows: (1) during the first year of the Agreement or during the first year following any lapse and reinstatement, or re-enrollment, a period of 30 days; (2) during the second and subsequent years of continuous coverage, a number of full calendar months most nearly equivalent to one-fourth the number of months of continuous coverage from the first annual anniversary of the date of issue or reinstatement or re-enrollment, whichever date is more recent, to the date of mailing of such notice, provided, however, that no period of required notice shall exceed 2 years and no renewal hereunder shall renew the Agreement for any period beyond the required period of notice except by written agreement of the Applicant and Blue Cross.

E. After 2 years from the date of issue of this Agreement no misstatements, except fraudulent misstatements made by the Applicant in the Application for such Agreement, shall be used to void said Agreement, or to deny benefits for a claim incurred commencing after the expiration of such 2 year period.

ARTICLE IV. GENERAL CONDITIONS

Section 1. Reports and Records

A. The Subscriber agrees that the Applicant's Agent may make available to Blue Cross for inspection any employment and other personnel records which have a bearing upon the eligibility of the Enrolled Group or its Applicants.

B. Blue Cross has the right at any time to require to be furnished to it without cost or expense, as a condition precedent to liability for any claim for services under the provisions of this Agreement, the history of treatment of the Subscriber maintained or possessed by a hospital, doctor, or any other institutional or professional provider of medical services and supplies; and each Subscriber by accepting this Agreement, does fully authorize, empower, and direct such hospital, doctor, institution or provider to furnish Blue Cross with such complete history upon request; and in case of a dispute as to liability and such claim is placed in litigation, each Subscriber for himself and heirs and attorneys does hereby expressly waive the privileges and benefits of any and all laws and rules which are now in force or may hereafter be enacted or promulgated in regard to disqualifying any doctor, nurse, hospital official or employee or any other institutional or professional provider of medical services and supplies from testifying concerning any information obtained by him or her in a professional capacity, or which make such information or knowledge privileged; and each Subscriber hereunder does for himself, his heirs, and attorneys expressly authorize and direct such doctor, nurse, hospital

official or employee or any other institutional or professional provider of medical services and supplies to make such full disclosure in the hearing, investigation, or trial concerning the liability of Blue Cross for the payment of such claim.

Section 2. Cooperation

The Subscriber agrees to cooperate fully with Blue Cross, and to recognize and be governed by the rules and regulations of the public authorities and of the hospital which he selects concerning patients and the right of physicians to practice therein, that any notice mailed by Blue Cross to the Applicant's last address as it appears in the records of Blue Cross, or in the case of a Group Subscriber any notices given to the Applicant's Agent shall be deemed to have been received by the Applicant, and that he will submit promptly to Blue Cross all forms requested.

Section 3. Termination of Member Hospital or Member Extended Care Facility Contracts

The contract between Blue Cross and a Member Hospital or a Member Extended Care Facility may be terminated, without notice to the Subscriber, in accordance with the provisions thereof, provided however, in the event of such termination, the Member Hospital or the Member Extended Care Facility shall continue to render services and facilities to such Subscribers as may be in-patients at the time of such termination or who are admitted during the 90 day period following the date of such termination.

Section 4. Determination of Service

For purposes of this Agreement, Blue Cross determination of the benefit provisions applicable for the services rendered a Subscriber hereunder, shall be conclusive.

Section 5. Selection of Physician

This Agreement does not confer upon any Member Hospital or Member Extended Care Facility the right to select any physician for the Subscriber. The Subscriber shall be at liberty to select his physician provided only that such physician shall be a member of the medical staff of, or acceptable to, the hospital or the extended care facility to which the Subscriber is admitted, and nothing contained in this Agreement shall interfere with the relationship between the Subscriber and such physician selected by the Subscriber, nor be construed to interfere with the arrangements now existing or which may hereafter exist between physicians and Member Hospitals or Member Extended Care Facilities and both physicians and Member Hospitals and Member Extended Care Facilities shall be at liberty to adjust their arrangements as they may agree.

Section 6. Epidemic and Emergency Conditions

In case of war, public disaster, public emergency, general epidemic, or any other conditions that prevent all of the Member Hospitals from providing hospitalization to Subscribers, Blue Cross shall credit to the Applicants not then receiving and unable to receive hospitalization a pro-rata return of unearned subscription charges for such period of time as Member Hospitals cannot furnish hospitalization, or upon demand shall pay such pro-rata return of unearned subscription charges in cash, which credit or payment shall be in full discharge to Blue Cross of liability hereunder. The amount of credits or cash refunds hereunder shall be subject to the approval of the Insurance Department of the Commonwealth of Pennsylvania.

Section 7. Effective Date and Term

This Agreement shall be effective from the date of its issuance, as that date appears on the records of Blue Cross, for a term of one (1) month and from month to month thereafter upon payment and acceptance by Blue Cross of the charges due and upon compliance with the terms and provisions of this Agreement or any renewal thereof, provided that in all cases where this Agreement is issued to an Applicant with whom Blue Cross has previously entered into a Subscription Agreement which is still in effect this Agreement shall, as of the date of its issuance, supersede the previous Subscription Agreement and the Application for the previous Subscription Agreement shall be recognized as and shall become the Application for this Agreement.

Section 8. Contract

This Agreement, together with any amendments or endorsements issued by Blue Cross, shall constitute the entire contract between the parties. No agent or employee is authorized to vary, add to, or change this Agreement in any manner or degree. No action at law or in equity shall be maintainable against Blue Cross for any claim unless brought within two years from the date of the beginning of the services involved. In the event the Subscriber becomes a party to more than one Agreement with Blue Cross providing for the benefits covered by this Agreement, only the first of such Agreements shall be valid and all subsequent Agreements shall be void and without effect.

ARTICLE V. CHANGE IN STATUS AND CHARGES

Section 1. Change of Employment

If the Applicant leaves the employ of a concern where he is a member of an Enrolled Group and is re-

employed by another concern having an Enrolled Group, he shall transfer to such Enrolled Group and remit through such Enrolled Group, but if he is retired, unemployed or employed by another concern having no Enrolled Group, the Applicant shall no longer be deemed to be a member of an Enrolled Group and his charges shall be payable directly to Blue Cross at Non-Group rates and he shall be entitled to the benefits then afforded Non-Group Subscribers.

Section 2. Death of Applicant Subscriber

In the event of the death of the Applicant Subscriber, this Agreement shall terminate at the end of the current monthly term. The surviving Subscribers hereunder shall, however, be entitled to Blue Cross coverage by applying, within 60 days of such termination, for a Subscription Agreement of the type for which they are then qualified at the rates then in effect.

Section 3. Marriage of Child or Attainment of 19th Birthday

Upon marriage or attainment of 19 years of age by any child of the Applicant Subscriber, coverage of such child shall terminate at the end of the Current Agreement Year. Such child shall, however, be entitled to a Subscription Agreement of the type for which he is then qualified by applying therefor within 60 days of such termination.

Section 4. Continuation of Incapacitated Child

In the event that an unmarried child is incapable of self support because of mental or physical incapacity and is dependent on the Applicant Subscriber for over half of his support, the Applicant may apply to Blue Cross

to continue the coverage of such child under this Agreement upon such terms and conditions as Blue Cross may determine provided, however, that the coverage of the dependent child thereunder shall terminate upon marriage of such child.

Section 5. Change of Non-Group Applicant's Residence

If a Non-Group Applicant changes his residence to an area served by another Blue Cross Plan, such Applicant shall apply to the Blue Cross Plan serving that area for the issuance of an agreement of the type for which he shall then be qualified. If such Applicant fails to apply for such an agreement within 60 days, or upon the issuance of such an agreement, this Agreement shall terminate.

Section 6. Discontinuance of an Enrolled Group

If the Applicant's Agent discontinues the remittance of charges for the Enrolled Group, or if the requirements for acceptance by Blue Cross of Enrolled Groups are not maintained, said Enrolled Group shall be deemed to have been discontinued and this Agreement shall terminate. Such Applicant shall be entitled to apply to Blue Cross for the issuance of an Agreement of the type for which he shall then be qualified, which Agreement shall become effective if and when such application is accepted by Blue Cross.

Section 7. Other Changes in Status

The addition or removal of a child or spouse (married applicants must enroll spouse unless applicant is a member of a Blue Cross Group where employer pays part or all of the charges, or is covered by Medicare) and changes between Individual and Family Agreements and changes from Non-Group to Group Classification and enrollment under another type of Agreement issued by Blue Cross shall be made upon such terms and conditions as Blue Cross may determine. Applications for such changes or enrollment shall be filed on the forms of Blue Cross and shall become effective and a part of this Agreement upon acceptance by Blue Cross.

Section 8. Charges

A. The charges for this Agreement shall be based upon the administrative requirements of Blue Cross, the cost of hospital service, extended care facility service and the indemnity for the certain medical services rendered when incident to hospitalization and shall be payable in advance according to the mode of payment agreed upon.

B. In the event the Applicant Subscriber is included in a category of Subscribers which has been approved by the Insurance Department of the Commonwealth of Pennsylvania for Merit Rating, this Agreement is subject to Merit Rating in accordance with the Formula currently filed with and approved by the Insurance Department and the charges for this Agreement may be modified periodically as a result of the application of said Formula. In the event of such modification of the charges, the Applicant Subscriber shall be notified, it being agreed that notice to the Applicant's Agent is notice to the Applicant and that payment of the new charge, resulting from the application of the Merit Rating Formula, shall be considered receipt of notice and acceptance of the modification in charge. Upon receipt of such payment, Blue Cross will duly record the Applicant's acceptance of the Modification. In the absence of such payment, this Agreement shall terminate 30 days after the new charge became due and payable.

C. In the event the Applicant Subscriber is included in a category of Subscribers which has not been approved

by the Insurance Department of the Commonwealth of Pennsylvania for Merit Rating, the charges for this Agreement shall be in accordance with the Schedule of Charges currently filed with and approved by the Insurance Department. The Board of Directors of Blue Cross, subject to the approval of the Insurance Department, may change the amount of charges for this Agreement but such change shall not become effective until the expiration of the period covered by the Applicant's current payment at the time of such change. In the event of such change, the Applicant Subscriber shall be notified, it being agreed that notice to the Applicant's Agent is notice to the Applicant, and that payment of the new charge shall be considered receipt of notice and acceptance of the change in charge. Upon receipt of such payment Blue Cross will duly record the Applicant's acceptance of the change. In the absence of such payment, this Agreement shall terminate 30 days after the new charge became due and payable.

Section 9. Default in Payment of Charges and Reinstatement

If the Applicant fails to pay to Blue Cross the charges for this Agreement within 30 days after the same became due, this Agreement shall automatically terminate at the end of the period for which payment has been made. Blue Cross may, thereafter, at its option, accept payment of the charges due and upon acceptance shall reinstate this Agreement effective immediately as to benefits provided herein for injury occurring, thereafter, and for such illness as may be first manifested more than 10 days after the date of such acceptance.

ARTICLE VI. DEFINITIONS

The following definitions shall apply to this Agreement except where the context clearly indicates otherwise:

Section 1. Admission: The term "Admission" shall mean the actual entry into a hospital or extended care facility of a Subscriber who is to receive in-patient services while lodged in the hospital or extended care facility and shall continue until such time as the Subscriber is actually discharged from such institution.

Section 2. Agreement and Subscription Agreement: The terms "Agreement" and "Subscription Agreement" shall mean this contract between the Applicant and Blue Cross.

Section 3. Agreement Year: The term "Agreement Year" shall mean the 12-month period beginning with the effective date of this Agreement and each subsequent 12-month period beginning with the anniversary date of such effective date.

Section 4. Applicant and Applicant Subscriber: the terms "Applicant" and "Applicant Subscriber" shall mean the individual who applies for and with whom Blue Cross has entered into this Agreement.

Section 5 Applicant's Agent: The term "Applicant's Agent" shall mean any individual, association, corporation or other entity which, as representative of an Enrolled Group of Applicants and as Agent for the Applicant is acceptable to Blue Cross and has agreed to pay the charges payable under this Agreement to Blue Cross and to receive any information from Blue Cross on behalf of the Applicant.

Section 6. Application and Application Card: The terms "Application" and "Application Card" shall mean the written request of the Applicant for a Subscription Agreement, set forth on the approved Blue Cross printed form for this purpose, whether such written request was made for this Agreement or for a previous Agreement

between the Applicant and Blue Cross which has been superseded by this Agreement.

Section 7. Blue Cross: The term "Blue Cross" shall mean Blue Cross of Greater Philadelphia.

Section 8. Child: The term "Child" shall include the following when living in the household of the Applicant in a normal parent-child relationship: the Applicant's natural son or daughter, or legally adopted child (including a foster child pending formal adoption), or stepchild.

Section 9. Eligible Dependents: The term "Eligible Dependents" shall mean the spouse and unmarried children of the Applicant (as provided in Article V Section 3) provided that the charges paid for this Agreement cover such dependents.

Section 10. Extended Care Facility: The term "Extended Care Facility" shall mean an institution or a distinct part of an institution licensed or approved as such under state or local law, primarily engaged in providing skilled nursing care and related services for patients who require such medical or rehabilitative services which is approved by the Joint Commission on Accreditation of Hospitals or by Blue Cross.

Section 11. Group and Enrolled Group: The term "Group" and "Enrolled Group" shall mean a group of Subscribers which has been accepted by Blue Cross, consisting of all those actively employed Applicants whose charges are remitted by the Applicant's Agent, together with all the Subscribers listed on the application cards or amendments thereof of such Applicants, which Subscribers have been accepted by Blue Cross.

Section 12. Hospital: The term "Hospital" shall mean a hospital licensed or approved for operations as such by

the applicable State Agency in which it is located and approved by the Joint Commission on Accreditation of Hospitals, by the American Osteopathic Hospital Association or by Blue Cross.

Section 13. Inter-Plan Hospital: The term "Inter-Plan Hospital" shall mean a hospital which has a contract with a hospital service Blue Cross Plan, other than Blue Cross of Greater Philadelphia, which is an eligible participant of the Inter-Plan Service Benefit Bank.

Section 14. Member Hospital: The term "Member Hospital" shall mean a hospital with which Blue Cross has a contract for the rendering of benefits under this Agreement.

Section 15. Member Extended Care Facility: The term "Member Extended Care Facility" shall mean an Extended Care Facility with which Blue Cross has a contract for the rendering of benefits under this Agreement.

Section 16. Non-Member Hospital: The term "Non-Member Hospital" shall mean a school infirmary or a hospital other than a Member Hospital or an Inter-Plan Hospital which is approved by the Joint Commission on Accreditation of Hospitals, the American Osteopathic Hospital Association or by Blue Cross.

Section 17. Non-Member Extended Care Facility: The term "Non-Member Extended Care Facility" shall mean an Extended Care Facility other than a Member Extended Care Facility.

Section 18. Subscriber: The term "Subscriber" shall mean the Applicant and all Eligible Dependents. All Subscribers whose charges are remitted to Blue Cross at group rates shall be classified as Group Subscribers and all other Subscribers shall be classified as Non-Group Subscribers.

Exhibit 6B

DIAGNOSTIC X-RAY, DIAGNOSTIC MEDICAL, DIAGNOSTIC PATHOLOGY, AND ANESTHETIC AGREEMENT

THIS AGREEMENT, made between the Applicant named in the Application therefor and PENNSYLVANIA BLUE SHIELD, a Pennsylvania non-profit corporation, hereinafter called Blue Shield.

ENTITLES the Applicant, in consideration of payment in advance of the appropriate subscription rates, to have Blue Shield pay for those Services hereinafter set forth, performed for the Applicant and all Eligible Dependents, all subject to the definitions, terms, conditions, and provisions set forth in this Agreement.

ARTICLE I. DEFINITIONS

Applicant shall mean the individual who applies for this Agreement.

Applicant's Annual Income shall mean the total income (for the twelve-month period immediately preceding the date of the performance of each Service hereunder) of the Applicant, his spouse, his eligible dependents, and any other persons whose chief support is furnished by the Applicant or the Applicant's spouse.

Application shall mean the written request of an Applicant for an Agreement, set forth on the form furnished by Blue Shield, together with any amendments or modifications thereof, whether such written request was made for this Agreement or for a previous Blue Shield Agreement which has been superseded by this Agreement.

Conversion Subscriber shall mean a Subscriber who leaves a Blue Shield Group and continues his membership

Exhibit 6B

in Blue Shield by remitting the subscription rate directly to Blue Shield at the non-group rate.

Effective Date shall mean the date that this Agreement is effective, as shown on the records of Blue Shield.

Eligible Dependents shall mean the spouse of the Applicant and all unmarried dependent children until they attain 19 years of age, provided that the subscription rate paid covers such dependents; and unmarried dependent children 19 years of age or older who, in the judgment of Blue Shield, are incapable of self-support by reason of physical or mental disability, provided that the rate paid covers such dependents, and that such dependents must be continuously supported by the Applicant.

Plan A shall mean that Plan under which the Subscriber is entitled to have Blue Shield pay for Services in accordance with Fee Schedule A.

Plan B shall mean that Plan under which the Subscriber is entitled to have Blue Shield pay for services in accordance with Fee Schedule B.

Fee Schedule (designated as either Fee Schedule A or Fee Schedule B) shall mean the list of procedures and amounts indicating the maximum Blue Shield payments for the respective Services performed for Subscribers, as filed with and approved by the Insurance Commissioner of the Commonwealth of Pennsylvania from time to time.

Group Subscriber shall mean a Subscriber whose subscription rate is collected and remitted to Blue Shield by a Remitting Agent along with the rates of other Subscribers, all of whom have been accepted as a Group by Blue Shield.

Identification Card shall mean the currently effective card which is issued to an Applicant evidencing the issuance of this Agreement.

Non-Group Subscriber shall mean a Subscriber who is not a Group or Conversion Subscriber.

Participating Doctor shall mean a doctor with whom Blue Shield has a contract with respect to Services performed for Subscribers.

Remitting Agent shall mean any individual, firm, association or corporation which, as representative of an enrolled group of Subscribers and as their agent, is acceptable to Blue Shield and has agreed to collect or pay the subscription rates respectively payable by such Subscribers and to remit the same to Blue Shield. Such Remitting Agent is not an agent of Blue Shield.

Services shall mean the Services set forth hereinafter when medically necessary and when performed by a doctor of medicine, osteopathy, dental surgery or podiatry within the scope of his license.

Subscriber shall mean collectively the Applicant and all Eligible Dependents.

ARTICLE II. SERVICES

A. Diagnostic X-Ray Services

The Subscriber, subject to the provisions and conditions hereinafter set forth, shall be entitled to diagnostic X-ray examinations, made either in or out of the hospital, which are required in the diagnosis of any condition due to disease or injury which are:

1 Ordered by a doctor of medicine, osteopathy, dental surgery or podiatry who is engaged in general or special practice other than radiology and when so ordered are made by a doctor of medicine or osteopathy, other than the doctor ordering such X-ray examinations, who limits his practice to radiology; *or*

2 Made by a doctor of medicine or osteopathy qualified to undertake radiological examinations within the confines of a single specialty; *or*

3 Made by a doctor of medicine, osteopathy, dental surgery or podiatry in emergencies or emergency traumatic cases.

The additional provisions and conditions under which the Subscriber shall be entitled to the diagnostic X-ray Services heretofore set forth are:

1 The Subscriber shall be liable to pay the first $5 (hereinafter called the "deductible") for any such examination or series of examinations within any period of four (4) consecutive days;

2 Blue Shield shall pay for such examinations the applicable fee listed in the Fee Schedule (or the doctor's charge, whichever is lower), less the deductible; provided, however, that in the case of Non-Group Subscribers, such diagnostic X-ray Services will not be available unless and until this Agreement has been in force twelve (12) complete consecutive months, for the diagnosis of any condition, disease or injury which exists at or before the Effective Date of this Agreement.

B. Diagnostic Medical Services

The Subscriber, subject to the provisions and conditions hereinafter set forth, shall be entitled to the following types of diagnostic medical examinations:

a. Cardiographs

b. Basal Metabolism

c. Electroencephalograms

d. Radioisotopic studies

made either in or out of the hospital, which are required in the diagnosis of any condition due to disease or injury; provided, however, that such diagnostic medical examinations shall be made or ordered by a doctor of medicine or osteopathy.

The additional provisions and conditions under which the Subscriber shall be entitled to the diagnostic medical Services heretofore set forth are:

1 The Subscriber shall be liable to pay the first $5 (hereinafter called the "deductibe") for any such examinations or series of examinations within any period of four (4) consecutive days;

2 Blue Shield shall pay for such examinations the applicable fee listed in the Fee Schedule (or the doctor's charge, whichever is lower), less the deductible; provided, however, that in the case of Non-Group Subscribers, such diagnostic medical Services will not be available unless and until this Agreement has been in force for twelve (12) complete consecutive months, for the diagnosis of any condition, disease or injury which exists at or before the Effective Date of this Agreement.

C. Diagnostic Pathological Services

The Subscriber, subject to the provisions and conditions hereinafter set forth, shall be entitled to diagnostic pathological examinations, made either in or out of the hospital, which are required in the diagnosis of any condition due to disease or injury; provided, however, that such diagnostic pathological examinations shall be made

or ordered by a doctor of medicine, osteopathy, dental surgery or podiatry.

The additional provisions and conditions under which the Subscriber shall be entitled to the diagnostic pathological Services heretofore set forth are:

1 The Subscriber shall be liable to pay the first $5 (hereinafter called the "deductible") for any such examinations or series of examinations performed within a period of four (4) consecutive days;

2 Blue Shield shall pay for such examinations the applicable fee listed in the Fee Schedule (or the doctor's charge, whichever is lower), less the deductible; provided, however, that in the case of Non-Group Subscribers, such diagnostic pathological Services will not be available unless and until this Agreement has been in force for twelve (12) complete consecutive months, for the diagnosis of any condition, disease or injury which exists at or before the Effective Date of this Agreement.

D. Anesthetic Services

The Subscriber shall be entitled to anesthetic Services in or out of the hospital, consisting of the administration of spinal anesthetic, or the administration of rectal anesthetic, or the administration of a drug or other anesthetic agent by injection or inhalation, (but excluding the administration of local infiltration anesthetic), the purpose and effect of which administration are the obtaining of muscular relaxation, loss of sensation, and loss of consciousness, performed by (or under the direct personal supervision of) a doctor of medicine, osteopathy or dental surgery other than the operating surgeon or his assistant in connection with the performance of:

1 Surgical services by a doctor of medicine, osteopathy or podiatry; provided, however, that in the case of Non-Group Subscribers, anesthetic Services will not be available in connection with surgical services for: (1) any condition, disease or injury which exists at or before the Effective Date of this Agreement, unless and until this Agreement has been in force for twelve (12) complete consecutive months; and (2) a tonsillectomy and/or adenoidectomy, unless and until this Agreement has been in force for six (6) complete consecutive months.

2 Obstetrical delivery services by a doctor of medicine or osteopathy; provided, however, that anesthetic Services will not be available in connection with obstetrical delivery services, unless and until this Agreement has been in force for eight (8) complete consecutive months.

3 Oral surgical services consisting of cutting procedures for the treatment of diseases and injuries of the jaw, or any structure contiguous to the jaw, the treatment of fractures and dislocations of the jaw or any facial bone, and the extraction of impacted teeth when partially or totally covered by bone; provided, however, that in the case of Non-Group Subscribers, anesthetic Services will not be available in connection with oral surgical services for any condition, disease or injury which exists at or before the Effective Date of this Agreement, unless and until this Agreement has been in force for twelve (12) complete consecutive months.

The amount payable by Blue Shield for the aforesaid anesthetic Services shall be computed in accordance with the Plan B Fee Schedule, less any amount payable under

a Hospital Service Contract; provided, however, that in the case of Subscribers enrolled with Blue Shield under a Plan A Agreement the amount payable shall be computed in accordance with the Plan A Fee Schedule, less any amount payable under a Hospital Service Contract. If anesthetic Services are performed in connection with more than one operation or procedure, the amount payable shall be based on the total fee payable for all such operations or procedures as set forth in the applicable Fee Schedule. In no event shall the amount payable be greater than the doctor's (anesthesiologist's) charge, less any amount payable under a Hospital Service Contract.

ARTICLE III. FURTHER PROVISIONS UNDER WHICH SERVICES WILL BE PROVIDED

A. Determination of Type of Service

Determination by Blue Shield as to whether the type of Service performed for a Subscriber is Diagnostic X-ray, Diagnostic Medical, Diagnostic Pathological, or Anesthetic, shall be conclusive.

B. General Limitations

The services performed for Subscribers shall not include the following:

1 Services for any occupational condition, ailment or injury arising out of and in the course of covered employment under Workmen's Compensation or Occupational Disease Laws, Federal Employers' Liability Acts or other similar State or Federal legislation; or provided by the United States Veterans Administration; or provided without cost to the Subscriber by any Federal, State, County or Municipal

hospital, agency, or instrumentality; or the cost of which has been or is later recovered in any action at law or in compromise or settlement of any claim.

2 Services or supplies provided by any governmental body or instrumentality, whether federal, state or local, pursuant to any program under which any periodic payment of premium, rate, enrollment fee or other similar charge is made by or for the Subscriber.

3 Services not incident or necessary to diagnosis or treatment of a sickness or injury.

4 Diagnostic X-ray, diagnostic medical and diagnostic pathological Services in connection with pregnancy, research studies, premarital examinations, fluoroscopy without films, routine procedures provided on admission to a hospital, or any examination not incident to or necessary to diagnosis of a sickness or injury.

5 Services in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting teeth; and including but not limited to the following: apicoectomy, root canal treatments, soft tissue impactations, gingivectomy and alveolectomy.

6 Services in connection with plastic operations for cosmetic or beautifying purposes, except those which are performed to correct a condition resulting from an accident occurring on or after the Effective Date of this Agreement.

7 Services in connection with the treatment of corns, bunions (except capsular or bone surgery therefor), callouses, nails of the feet (except surgery for ingrown nails), flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet (except when surgery is performed).

8 Services for which the fees or charges are claimed by hospitals, laboratories, or other institutions; or when the services are covered to any extent under a Hospital Service Contract.

9 Services in a hospital performed by a doctor who in any case is compensated by the hospital for similar Services when performed for patients.

10 Services performed by doctors of medicine, osteopathy, dental surgery or podiatry who do not themselves bill patients for such Services.

C. Payment for Services of Participating Doctors

1 With respect to diagnostic X-ray, diagnostic medical, and diagnostic pathological Services, payment shall be made in accordance with Blue Shield's Plan B Fee Schedule as follows:

a. Participating Doctors who perform such Services for Subscribers enrolled hereunder shall make no charge, other than the deductible, if the Applicant is single and without any person or persons dependent upon him for their chief support, and if the Applicant's Annual Income, as hereinbefore defined, does not exceed $4,000; or if the Applicant is married or has any other person or persons dependent upon him for their chief support, and if the Applicant's Annual Income, as hereinbefore defined, does not exceed $6,000.

b. If the Subscriber does not qualify for Services to be performed without charges, as hereinbefore set forth, Blue Shield will pay the Participating Doctor for the Services in accordance with the Plan B Fee Schedule, or the amount charged by the doctor, whichever is lower, less the deductible. If the doctor charges in such cases an amount in excess of the amount fixed in the Plan B Fee Schedule, it shall be the personal responsibility of the Subscriber to pay such difference to the doctor.

c. Payment by Blue Shield of the amount charged or the amount fixed in the Plan B Fee Schedule, whichever is lower, less the deductible, for any such Service, shall constitute full discharge of Blue Shield's liability hereunder with respect to such Service.

2 With respect to anesthetic Services, payment shall be made in accordance with Blue Shield's Plan A or B Fee Schedule as follows:

a. Participating Doctors who perform such Services for Subscribers with respect to whom the Plan A Fee Schedule is applicable as provided in paragraph D of Article II shall make no charge for such Services if the Applicant is single and without any person or persons dependent upon him for their chief support, and if the Applicant's Annual Income, as hereinbefore defined, does not exceed $2,500; or if the Applicant is married or has any other person or persons dependent upon him for their chief support, and if the Applicant's Annual Income, as hereinbefore defined, does not exceed $4,000.

b. Participating Doctors who perform such Services for Subscribers with respect to whom the Plan B

Fee Schedule is applicable as provided in paragraph D of Article II shall make no charge for such Services if the Applicant is single and without any person or persons dependent upon him for their chief support, and if the Applicant's Annual Income, as hereinbefore defined, does not exceed $4,000; or if the Applicant is married or has any other person or persons dependent upon him for their chief support, and if the Applicant's Annual Income, as hereinbefore defined, does not exceed $6,000.

c. If the Subscriber does not qualify for Services to be furnished without charge as hereinbefore set forth, Blue Shield will pay the Participating Doctor for the Services in accordance with the applicable Fee Schedule (A or B) or the amount charged by the doctor, whichever is lower, less in either case any amount payable under a Hospital Service Contract. If the doctor charges in such cases an amount in excess of the amount fixed in the applicable Fee Schedule, it shall be the personal responsibility of the Subscriber to pay such difference to the doctor.

d. Payment by Blue Shield of the amount charged or the amount fixed in the applicable Fee Schedule, whichever is lower, less any amount payable under a Hospital Service Contract for any anesthetic Service, shall constitute full discharge of Blue Shield's liability hereunder with respect to such Service.

D. Payment for Services of Non-Participating Doctors

If any Service covered by this Agreement is performed for a Subscriber in an emergency by a doctor of medicine, osteopathy, dental surgery or podiatry who is not a Participating Doctor, Blue Shield will pay the

Exhibit 6B

amount charged or the amount fixed by this Agreement and the applicable Fee Schedule, whichever is lower, which payment shall constitute full discharge of Blue Shield's liability hereunder with respect to such Service.

E. Identification

The Applicant's Identification Card must be presented to the doctor when the Service is requested.

F. Settlement of Disputes

Any dispute between a Participating Doctor and a Subscriber with respect to the Applicant's Annual Income shall be submitted to and determined by Blue Shield and such determination by Blue Shield shall be conclusive.

G. Information and Records

The Subscriber agrees that any doctor, practitioner, nurse, or any hospital or similar institution may furnish and is hereby autho ed to furnish to Blue Shield, at any time upon its request, any and all information and records or copies of records relating to any examination, diagnosis, treatment or service performed for the Subscriber and to give testimony with respect thereto.

H. Contest

No action at law or in equity may be commenced by any Subscriber with respect to any Services performed for such Subscriber under this Agreement until thirty (30) days after Blue Shield shall have received a report of the Services involved completed on the form furnished by Blue Shield and signed by the doctor performing the Services, nor shall any such action be brought at all later than two (2) years after the performance of the Services involved.

Exhibit 6B

I. Assignment

Any rights of a Subscriber to receive Services or payments hereunder are personal to the Subscriber and may not be assigned.

J. Duplicate Blue Shield Coverage

In the event any Services to which a Subscriber is entitled under this Agreement are also covered under another Blue Shield Agreement, Blue Shield may elect to treat either one of such Blue Shield Agreements void and without effect, beginning with the date the second of such Agreements became effective.

K. Subrogation

In the event any Service is provided or any payment is made to a Subscriber under this Agreement, Blue Shield shall be subrogated and succeed to the Subscriber's rights of recovery therefor against any person, firm, corporation, or organization except against insurers on policies of insurance issued to and in the name of the Subscriber. The Subscriber shall execute and deliver such instruments and take such other action as Blue Shield may require to secure such rights. The Subscriber shall do nothing to prejudice the rights given Blue Shield by this paragraph without its consent.

L. Statutory Limitation of Blue Shield Liability

Blue Shield shall not be liable for injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice, on the part of any officer or employee or on the part of any doctor of medicine, doctor of ostepathy, doctor of dental surgery or doctor of podiatry in the course of performing Services for Subscribers.

ARTICLE IV. SUBSCRIPTION RATES

The Applicant agrees to pay to Blue Shield, in advance as billed, the applicable subscription rate set forth in the Schedule of Rates filed with and approved by the Insurance Commissioner of the Commonwealth of Pennsylvania.

Blue Shield, subject to the approval of the Insurance Commissioner of the Commonwealth of Pennsylvania, may change the subscription rates for this Agreement, but such change shall only be effective upon thirty (30) days' notice to the Applicant or to the Remitting Agent. Payment by the Applicant of the new rate shall be deemed receipt of notice and acceptance of the change in rate. If the Applicant does not pay the new rate when it becomes effective, this Agreement shall terminate as of the end of the period covered by the subscription rate payment made by the Applicant immediately prior to the receipt of notice of the change in rate.

ARTICLE V. CONTRACT AND DURATION THEREOF

A. Contract

This Agreement and the Application therefor, together with any amendments thereto, the applicable Fee Schedule, and the appropriate subscription rate shall constitute the entire contract between the parties. No agent or employee of Blue Shield is authorized to vary, add to, or change this contract in any manner or degree, except as specifically provided herein.

B. Term and Renewal

Subject to such amendments to this Agreement as may be approved from time to time by the Insurance

Commissioner of the Commonwealth of Pennsylvania, this Agreement shall remain in effect from month to month unless notice of election to terminate it is given by the Applicant to Blue Shield or by Blue Shield to the Applicant, not less than thirty (30) days prior to the date of termination. Failure to pay the applicable subscription rate when due shall automatically terminate this Agreement and all benefits hereunder.

In the event the Subscriber becomes enrolled under the Federal Supplementary Medical Insurance Program for the Aged, Act of Congress, Public Law 89-97, Title XVIII, Part B ("Medicare Part B"), or any other governmental program whether federal, state, or local, Blue Shield reserves the right to give notice of election to terminate this Agreement but not less than thirty (30) days prior to the date of termination; provided, however, that the Subscriber shall have the right at the time of such termination to convert to such programs as Blue Shield may then have available to supplement such governmental programs.

ARTICLE VI. CONTINUANCE OF MEMBERSHIP

A. Transfer

If the Applicant leaves the employ of a concern having a Blue Shield Group and is reemployed by another concern having a Blue Shield Group entitled to similar Services, he shall transfer to such Blue Shield Group and remit his subscription rate through such Group's Remitting Agent.

B. Conversion

If the Applicant leaves the employ of a concern having a Blue Shield Group and is not employed, or is employed by another concern having no Blue Shield

Exhibit 6B

Group or having no health benefit plan with any other organization, the Applicant may elect to become a Conversion Subscriber.

C. TERMINATION OF GROUP

If the Applicant's Remitting Agent ceases to remit the subscription rate (other than for the reason stated hereinafter) for the Blue Shield Group for which it acts, such Group shall be deemed discontinued and the Applicant may elect to become a Conversion Subscriber. If the Applicant's Blue Shield Group participates in or secures coverage under a health benefit plan or arrangement made available by some other organization, such action shall automatically terminate this Agreement, and there shall be no right of conversion hereunder.

ARTICLE VII. NOTICE

Any notice mailed by Blue Shield to a Subscriber or to the Subscriber's Remitting Agent at the last address as shown on the records of Blue Shield shall be deemed notice to the Subscriber for the purpose of this Agreement.

Exhibit 14

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT
Harrisburg

The Commissioner

March 24, 1971

The Associated Hospital Service
of Philadelphia
1333 Chestnut Street
Philadelphia, Pennsylvania 19107

Re: Uniform Cost Contract 1967—
Revised Effective July 1, 1970

Gentlemen:

I hereby direct you to cancel all the above referred to contracts with member hospitals subject to immediate renegotiation. Amendment of these contracts within the guidelines indicated during the course of our recent hearings is to be completed prior to July 1, 1971.

You have already received a number of suggestions for the contract and you may except additional comments in the near future.

This confirms my earlier written and oral instructions.

Sincerely,

/s/ HERBERT S. DENENBERG
HERBERT S. DENENBERG

HSD:fw

Exhibit 15

GUIDELINES

1. *Duplicative and Underutilized Facilities and Services.*

It is generally agreed that there is a good deal of duplication and underutilized hospital facilities and services. Perhaps the classic example is open-heart surgery and certain types of hospital services, such as the pediatric and maternity division.

Some agency might be selected to determine which duplicative and underutilized facilities and services should be phased out and which new ones should be authorized for the future.

The Blue Cross-hospital contract negotiations should consider new approaches to the elimination of unnecessary and duplicative services.

2. *Elimination of Unsafe and Otherwise Substandard Beds.*

Blue Cross subscribers should not be called on to pay for the use of unsafe and unsuitable hospital beds. Blue Cross and the hospitals should consider not reimbursing for such beds and closing them down altogether. Certainly, in areas where there are excessive beds, there is no reason for not closing down beds and hospitals which are unsafe or otherwise unsuitable.

Some hospitals can be closed altogether. Other hospitals can close some units, and perhaps still maintain adequate beds by use of pre-admission testing, the seven-day work-week, and similar measures.

3. *Financing of Residents and Interns.*

The costs of residents and interns, as part of hospitals' reimbursable costs, have been rapidly escalating, and is a substantial cost factor. In medical school hospitals, this cost may run as high as $10. per day per patient and the end is not in sight.

Exhibit 15

One possibility is the transfer of this cost to the physicians themselves. Other possibilities should be explored. For example, some maximum limit for the costs of residents and interns might be established.

4. *Limitation on the Number of Employees.*

Many hospitals have increased their employee force, sometimes without any apparent increase in patient care. There is now no effective limitation on unnecessary personnel increases.

The contract should consider provisions to control increases in personnel and perhaps even rollbacks on present personnel. An agency might be selected to authorize any additional employees, including salaried physicians.

5. *Depreciation.*

Reimbursing for depreciation, as a hospital cost, has been a hotly debated question for some time. Some believe depreciation as a cost should be sharply limited or eliminated altogether. The cost implications of depreciations are substantial. The depreciation expenses at some hospitals may run $10. per day or more, and the aggregate bill for depreciation is sharply rising. It is clearly time to carefully reconsider this issue.

6. *Prospective Rating.*

There are inherent weaknesses in reimbursing on the basis of open-ended costs.

Consideration should be given to some form of prospective rating so a hospital's expenditures for a given period can be fixed in advance.

Consideration might also be given to determining a specified aggregate annual amount of money payable by

all Blue Cross subscribers, which would then be appropriately distributed to all participating facilities for all services to be rendered.

7. *Budgetary Review.*

Each hospital should operate on a budget, and these budgets should be submitted to Blue Cross in advance for prior review.

Hospitals, whose costs are out-of-line when compared to similar institutions, could then be so advised and appropriate corrective measures taken.

Consideration should be given to all methods of advance budgetary review and authorization.

8. *Adoption of Cost-Saving Devices.*

Hospitals have not taken advantage of proven cost-saving devices, such as pre-admission testing and graded care.

The contract should require such economies rather than merely offer incentives for their implementation. Consideration should be given to all such economies that can be built into the contract.

9. *Ancillary Services Provided by Physicians.*

The compensation arrangement for the services of ancillary specialists—anesthesiologists, pathologists and radiologists—often produce fantastic incomes. The Board of Trustees of some hospitals may not even be aware of the income produced by some of these percentage arrangements.

Consideration should be given to a contractual arrangement requiring disclosure of the actual levels of compensation produced by these arrangements. Boards of Trustees might consider setting a maximum dollar amount

on any compensation arrangement. Another possibility is to place all hospital-based physicians on fixed dollar salaries.

10. *Denial of Reimbursement for Costs of Some Organizations.*

Hospitals are reimbursed for their dues paid to such organizations as the Delaware Valley Hospital Council and the Hospital Association of Pennsylvania.

Consideration should be given to denial of reimbursement when dues are paid to more than one organization that may render the same services.

11. *Consumer Control of Hospitals.*

Our health delivery system is desperately in need of more consumer input. This is true of Blue Cross as well as the hospitals.

Consideration should be given to an appropriate contractual arrangement to assure adequate consumer representation on hospital Boards and vital committees.

12. *The Hospital: Country Club or Open Institution.*

Every step should be taken to subject the health delivery system to the influences of competition.

One important step in this direction would be authorization of physicians to practice in any hospital rather than imposing country club limitations on what physicians can practice in what hospital.

Consideration should be given to creating an open door policy for all physicians at all hospitals.

13. *Generic Drugs.*

It has been estimated that drug bills might be cut as much as 60 to 95 percent by the use of generic rather than brand-name drugs.

Exhibit 15

One possibility is to have all Blue Cross hospitals follow the procedures already used in several major medical institutions. There the doctor prescribes the drug under the brand-name he knows, on a prescription blank that carries a printed legend over the space for the doctor's signature that says the pharmacist may substitute a less expensive brand where available and identical chemically.

14. *Reimbursement for General Management Surveys.*

Blue Cross contracts may now provide for reimbursement for projects for design and implementation of more effective systems and procedures for furnishing quality patient care.

Such provisions should be broadened to include general management surveys and to otherwise obtain consultation on the basic issues of hospital management.

15. *Incentives for Cost-Saving Programs.*

Various incentives are included in Blue Cross contracts for certain cost-saving programs, such as preadmission testing.

In view of the urgent necessity for economies, consideration should be given to making these cost-saving programs mandatory and doing away with related incentive programs.

16. *Better Accounting for Excluded Research Costs.*

Blue Cross does not directly reimburse for research costs. There is reason to believe, however, that research costs may indirectly be comingled with patient care and thus become reimbursable for Blue Cross. The contract should develop standards to eliminate any reimbursement for research, even if indirect.

Exhibit 15

17. *Public Disclosure of Information.*

The public is entitled to and interested in full disclosure of financial and operational details relating to hospitals.

The contract should give due consideration to making this information available to the public. For example, the cost per day of a hospital stay, average length of stay, aspects of hospital expenses and other facts should be disclosed.

18. *Utilization Review.*

There is a great deal of evidence that the utilization review process is not working effectively and that there is substantial overutilization of hospital facilities.

Consideration should be given to contractual provisions containing new approaches to utilization review. Among suggested variations on the present review process is the inclusion of consumer and financial intermediary representatives on review committees.

19. *Protecting the Patient from Improper Charges.*

The patient is now frequently charged for hospitalization that should never have been ordered in the first place.

In such cases, the hospital should not charge for such services and arrangements should be made for the physician to pick up the tab in such cases.

Consideration should be given to every possible method of protecting the public from improper charges.

20. *Loss Prevention and Control Programs.*

The casualty insurance industry has developed proven methods for eliminating and minimizing hospital accidents

and resulting lawsuits. These lawsuits lead to astronomical costs and insurance premiums, and result in higher Blue Cross premiums.

Consideration should be given to requiring each hospital to implement needed safety measures.

21. *Blue Cross Guarantees of Hospital Bad Debts.*

The Blue Cross contract may now compensate hospitals for bad debts resulting from the inability to collect deductibles, coinsurance exclusions and similar amounts not paid by the applicable Blue Cross contract.

Consideration should be given to transferring the risk of such bad debts from the Blue Cross Plans to the hospitals.

22. *Effective Date of Contract.*

The economies and efficiencies to be built into the Blue Cross-hospital contract should not be unnecessarily postponed even for a day.

Consideration should be given to as early an effective date as possible.

23. *Participation in Hospital Statistical Agency Activities.*

Hospitals should participate in and use services provided by such organizations as the Professional Activities Studies (PAS) or the Hospitalization Utilization Projects (HUP). These services provide comparative data on utilization. Hospitals should also be required to explain any statistical variations significantly above like hospitals. For example, any higher than average stay in any category of major diagnosis should be explained.

24. *Use of Tests Performed Out of Hospitals.*

Hospitals should agree to accept tests and examinations done outside of hospitals by licensed laboratories. Evidence at the Blue Cross hearings indicated hospitals often needlessly duplicate outside tests and often, without good medical reasons, refuse to accept outside tests. This is so, even when the outside laboratories have quality control equal or better than the hospital's own laboratories. In one case, a doctor on the staff of the hospital indicated he could not even use his own outside tests in his own hospital.

25. *More Uniform Accounting.*

Hospitals should be required to move toward more uniform accounting to make the gathering, exchange and analysis of data easier for Blue Cross as well as others.

26. *Greater Use of Systems Departments.*

Should every hospital have a systems department to carry out departmental efficiency studies, with annual reports to Blue Cross? As one fiscal intermediary commented: "A systems department (even if only one talented man and a part-time clerk) can usually justify its existence and cost through review of needs and the establishment of goals and responsibilities, and selecting areas for quick investigation and quick pay-off in improvement of efficiency and cash savings".

27. *Strong Budget Committees with Outside Representation.*

Should every hospital have a budget committee, with outside representatives as well as trustee representatives, and specified composition?

28. *Use of Prudent Buying Practices.*

Special provisions should assure that hospitals are not purchasing merchandise at vastly inflated prices. Evidence at the Blue Cross hearings indicated hospitals may buy such items as scissors, tape measures and furniture through hospital supply companies at many times the cost of identical equipment through conventional channels. For example, one witness at our hearing indicated "hospitals'" tape measures might sell for $2.50 and "hospitals'" scissors for $7.50, but identical products could be bought elsewhere for $.25 and $2.49 respectively.

29. *Use of Departmental Accounting.*

Under Medicare, either the combination or departmental method of accounting may be used. The combination method of accounting results in overcharging Blue Cross subscribers by many millions of dollars. The departmental method presents a much more accurate accounting method and therefore should be used.

30. *Full Recognition of the Impact of the Wage-Price Freeze.*

The consumer is entitled to any savings from the wage-price, and any resulting savings should be built into the Blue Cross-hospital contract.

31. *Greater Consumer and Public Information and Participation in Hospital Board Meetings.*

Hospital Board meetings should be announced in advance and should be open to the public.

32. *Blue Cross Should be More Selective in Deciding What Hospitals to Contract With.*

If a hospital is substandard and does not deliver good quality medical care, it should not have the benefit of a

Blue Cross contract. Blue Cross should establish standards for hospitals and keep raising them from time to time. Eventually, Blue Cross should have contracts only with hospitals which meet all reasonable standards.

33. *Blue Cross Should Have the Right to Put Consultants Into Any Hospital.*

It is clear that hospitals often cover up inefficiencies and are afraid to let expert consultants come in to study them. We think that hospitals should open their doors to consultants as long as any extra costs of such consultants are paid by Blue Cross. Moreover, when the need is indicated, the hospital should have to bring in consultants at its own expense.

34. *Limiting Reimbursements when Occupancy Falls Below a Minimum Level.*

Consideration should be given to a contractual arrangement which would limit Blue Cross reimbursements when the level of occupancy of the hospital falls below a predetermined minimum. It is certain that extremely low occupancy facilities are both uneconomical and unsafe.

35. *Limitations on Reimbursement for Depreciation and Interest on Under-Financed or Excessively Costly Facilities.*

This is necessary to prevent the continued construction of excessively costly hospital facilities.

36. *Disclosure to the Patient of the Doctor's Interest in any Hospital which is Used for any Such Patient.*

A doctor's financial interest in a hospital is another of the flagrant conflicts of interest driving up the cost

of hospital care. Mandatory disclosure will bring a halt to this costly abuse.

37. *Cost Ceilings.*

There should be a maximum on reimbursable per diem costs from one year to the next. These should be done by groups of hospitals as noted in Guideline No. 52.

38. *Board Certified or Board Eligible Surgeons.*

In order to maintain high quality care and reduce the number of unnecessary surgical procedures, Blue Cross participating hospitals should, where practical, allow only board eligible or board certified specialists to practice their specialty. This could be waived for emergencies. In certain cases where this is not practical, the hospital board must publicly and in writing explain the reasons to Blue Shield.

39. *A Hospital Ombudsman.*

Each member Blue Cross hospital should be required to have an ombudsman to handle consumer complaints. The availability of the ombudsman and the formal complaint process should be explained to each patient on entering the hospital or on each use of the outpatient department.

40. *Consumer Advocates Against Physicians.*

When a dispute arises between a patient and his physician, Blue Cross and the hospital, where possible, should act as the patient's advocate. Blue Cross and the hospitals should explore formal methods of achieving this goal.

41. *Patients' Bill of Rights.*

Hospital should make each patient fully aware of his rights when admitted to the hospital. It has been evident that patients have numerous legal rights of which they are not aware while in the hospital. Blue Cross and the hospitals should see that every patient is fully informed.

42. *Counselors for Patients.*

In keeping the patients informed of their rights, alternatives of treatment and other information from admission through discharge, counselors should be available to patients.

43. *Discharge Coordinators on Utilization Review Committees.*

All Blue Cross member hospitals should have active and independent discharge coordinators. The discharge coordinator should be one of the non-physician representatives on all utilization review committees. The discharge coordination should log all discharges and actions and make this information available to Blue Cross.

44. *Questionnaires on Service.*

The hospital administration or the ombudsman should ask each discharged patient to respond to a questionnaire on service developed in conjunction with Blue Cross. The results of these questionnaires should be summarized and made available to Blue Cross on a regular basis. In turn, Blue Cross should use this information in evaluating the hospital for future contractual arrangements. Selected parts of this information might be used in advising consumers.

45. *Log All Hospital Complaints.*

The ombudsman or hospital administration should be required to log each individual complaint. As in the guideline above, this information should be forwarded to Blue Cross.

46. *Arbitration of Complaints.*

A formal and independent process should be established for the arbitration of consumer complaints against hospitals. The patient should have the right to take any complaint to the arbitration and the hospital should agree to go along with the recommendations.

47. *Use of Alternative Food Facilities.*

When patients are ambulatory and can use alternative food facilities, they should be permitted to do so and not be charged for meals in their room.

48. *Clear and Specific Hospital Bill.*

Each hospital should be required to itemize bills to patients in a clear and specific manner so that the patient knows what he is being billed for. Blue Cross might establish a minimum or standard. Each bill should inform the patient of his right to have his questions answered and of his access to complaint mechanisms.

49. *Conflict of Interest Statements by Boards and Key Personnel.*

Hospital boards and key personnel should be required to file annual conflict of interest statements with Blue Cross. Procedures should also be adopted to assure that any board members and other personnel do not participate in making decisions involving them in a conflict of interest situation.

50. *Billing Practices of Hospital Based Physicians.*

When hospital based physicians, such as anesthesiologists, pathologists and radiologists are allowed to bill the patient directly, the cost for care increases and there is a motive for overtreatment and unnecessary procedures. Contract arrangements should not permit such hospital based specialists to bill directly. Arrangements should be made to salary all such personnel. Existing contracts with specialists allowing direct billing arrangements should be terminated and renegotiated within the next six months.

51. *Blue Cross Should Eliminate Advances to Hospitals or Charge Hospitals Interest at Current Market Rates.*

For Blue Cross to make interest free advances to hospitals when other major third party purchasers are not unnecessarily inflates subscriber rates. Blue Cross should either eliminate the advance program or update it to require interest on the money which would be added to other investment income in developing subscriber rates.

52. *Grouping of Hospitals by Size and Function.*

Blue Cross should group hospitals for contractual purposes by size and function. Each of the guidelines could then be best developed to suit the particular class of hospitals. For example, teaching hospitals should be grouped together, large non-teaching hospitals should be grouped together, etc.

53. *Patients' Right to Select Anesthesiologist.*

Arrangements should be made to allow patients to choose the anesthesiologist. The patient should be advised in advance of the names of available anesthesiologists

and when they bill the patient directly, fee schedules should be given the patients.

54. *Patients Should Have Full Knowledge of Who is Performing Procedures.*

Hospitals should be required to inform patients in advance, when possible, of precisely who is performing procedures on them. This would be true for such cases where a nurse anesthetist is administering the anesthesia in place of an anesthesiologist or where the resident performs a procedure in place of the surgeon.

55. *Denial of Benefits for Unnecessarily Long Stays.*

The hospital contract should allow Blue Cross the right to deny portions of hospital stays deemed to be unnecessarily long. The procedure for denial could follow the present Medicare method.

56. *Development of Short Surgical Procedures Capabilities.*

Every hospital which is routinely providing general surgical facilities shall establish a capacity for providing short surgical procedures to outpatients within the next six months.

57. *Denial of Staff Privileges at All Hospitals.*

When one hospital dismisses a physician from its staff for reasons of competence, arrangements should be made for all member hospitals to reciprocate.

58. *Subpoena Notice.*

When a hospital receives a notice to turn over a patient's records, the patient should be notified as soon as possible.

59. *Notification of Malpractice.*

When a hospital discovers malpractice has been performed on a patient, the hospital should be under obligation to notify the patient.

60. *Responsibility of Hospital Trustee.*

The ultimate responsibility for all hospital operations rests with the board of trustees. An effort should be made to make sure hospital trustees are fully aware of their responsibility and that they are fully accepting these responsibilities.

The trustees of every hospital shall immediately establish necessary safeguards to prevent the facilities of the hospital from being made available to any physician for the performance of unnecessary surgical procedures.

61. *Community Effectiveness of Hospital Operation.*

Establish a method whereby at least bi-annually an independent appraisal of the community effectiveness of the operations of every hospital will be made and publicly reported.

62. *Depreciation, if any, Should be Placed in Community Pool.*

If the hospital patients are to pay for depreciation, this money should be placed in a central pool controlled by an independent Board of Trustees representing the patients who provided these funds. They will have the prime responsibility for determining which services or hospitals should be expanded or replaced.

63. *Limitation on the Cost of Nursing Education.*

Blue Cross is today reimbursing large portions of the education costs of schools of nursing. Contract arrange-

ments should be developed to limit cost reimbursement for such programs where services to the patients resulting from the programs are not commensurate to the costs. One approach would be a cost ceiling for reimbursement of such programs.

64. *Hospital By-Laws which Prohibit Physicians from Billing Patients for Unnecessary Admissions and Excess Stays.*

Hospital by-laws should provide that when a stay has been determined excessive or an admission is considered unnecessary by the review procedure, the physician shall agree not to bill the patient for his costs.

65. *Public Hearings on Hospital Budgets.*

A method should be developed to formally present hospital budgets and changes in services to the public before they are submitted to Blue Cross. Public hearings on such budgets and changes would be the best method of gaining public input.

66. *Available Emergency Information on Pharmacies.*

Hospitals should keep consumer information on the location and hours of pharmacies. This information should be made available by telephone as a service to the community.

67. *Implementation of Safety Recommendations.*

The hospitals should agree to implement all safety recommendations suggested by malpractice insurers. If such recommendations are not implemented, a written report as to why they cannot be implemented must be submitted to Blue Cross within 90 days.

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT

Harrisburg

DR. HERBERT S. DENENBERG
The Commissioner

June 6, 1973

Mr. Bruce Taylor, President
Blue Cross of Greater Philadelphia
Philadelphia, PA 19107

Dear Mr. Taylor:

I would like to take this opportunity to add the following guideline to our list which is currently being used in the negotiations between your plan and the Delaware Valley Hospital Council:

Guideline 68

The consumer is entitled to all information concerning the safety and operations of the hospital. To ensure this right, the present contract (Section 28) should be amended to specifically include the public release of all survey reports about the hospital issued by the Joint Commission on the Accreditation of Hospitals.

My staff and I have been carefully reading the transcripts of each of the negotiating sessions as they are forwarded to us. Please continue to keep us informed.

Sincerely,

/s/ HERBERT S. DENENBERG

HERBERT S. DENENBERG
Insurance Commissioner

Exhibit 15

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT

Harrisburg

The Commissioner

July 16, 1973

Mr. Bruce Taylor
President
Associated Hospital Service of
Philadelphia
1333 Chestnut Street
Philadelphia, Pennsylvania 19107

Dear Mr. Taylor:

Once again we should like to add additional guidelines to our list which is currently being used in your negotiations with the Delaware Valley Hospital Council. These guidelines are a result of our continued investigations of the health delivery system in Philadelphia and across the Commonwealth. We will continue to add to our list as further problems come to our attention.

The following are Guideline Numbers 69 and 70:

Guideline 69

It is nationally recognized that smoking is hazardous to the health of the smoker and often annoying to those around him. Such dangers and annoyances are especially true and often multiplied in the hospital environment. The Blue Cross contract should include provisions to separate smoking patients from non-smoking patients and forbid smoking in all areas of the hospital by visitors and staff.

Guideline 70

The langauge problem faced by non-English speaking patients in hospitals and outpatient clinics

Exhibit 15

is of acute concern in many urban areas. Blue Cross participating hospitals should agree to develop a network of translators throughout the area for all hospitals. Such a network could be in a voluntary basis and rely on resources of university language departments and all ethnic organizations in the area. In hospitals that serve large non-English speaking population, arrangements should be made for permanent bilingual staffs and translators.

We have been reading the transcripts of the negotiating sessions which have taken place to date. To say the least, we are disappointed that the hospitals have continued to ignore many of our recent guidelines which most certainly would result in higher quality hospital care at prices the public can afford.

We trust that you will submit these two new guidelines at the negotiations and continue to keep us informed.

Sincerely,

/s/ HERBERT S. DENENBERG

HERBERT S. DENENBERG

Exhibit 15

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT

Harrisburg

DR. HERBERT S. DENENBERG
The Commissioner

September 18, 1973

Mr. Bruce Taylor
President
Blue Cross of Greater Philadelphia
1333 Chestnut Street
Philadelphia, Pennsylvania 19107

Dear Mr. Taylor:

I am enclosing Guideline 71 to be added to your list of guidelines to be used in the negotiation of the Blue Cross contract with hospitals. Guideline 71 is as follows:

71. *Nondiscrimination At All Levels of Hospital Employment*

Hospitals are important employers of minorities and women, who all too often are found only at the lowest salary and skill levels. Hospitals should commit themselves to a policy of equal employment opportunity for all and should institute programs to eliminate barriers to the upward mobility of their minority, female, and other employees. The Blue Cross contract should include a strong nondiscrimination clause with provisions for reviews to insure compliance.

Best regards.

Sincerely,

/s/ HERBERT S. DENENBERG

HERBERT S. DENENBERG

Exhibit 16

COMMONWEALTH OF PENNSYLVANIA
Milton J. Shapp, Governor

Harrisburg

INSURANCE DEPARTMENT
William J. Sheppard, Acting Commissioner
Contact: David Nestor
Communications (717-787-3289)

FOR IMMEDIATE RELEASE

April 26, 1974

Acting Insurance Commissioner William J. Sheppard today called on the five Blue Cross Plans in Pennsylvania and Pennsylvania Blue Shield to continue their efforts toward controlling hospital costs.

Sheppard said, "Because federal economic controls on the health industry probably will be dropped as of April 30, 1974, the role of Blue Cross in protecting the public from skyrocketing hospital costs will be more important than ever.

"For the past three years, the Pennsylvania Insurance Department has taken a hard line, forcing Blue Cross Plans to negotiate contracts with cost and quality controls. I have no intention of backing away from this. Cost control is more important than ever," said Sheppard.

"Each of Pennsylvania's five Blue Cross Plans has negotiated new contracts with hospitals containing cost and quality provisions drafted by this Department. As a direct result, these contracts have been credited with saving the public many millions of dollars," he said.

Sheppard said, "Both Blue Cross and the hospitals deserve a great deal of credit for progress which has already been made. But we cannot be content to stop here.

Exhibit 16

As new contracts are developed, new methods of monitoring costs and quality must be developed. Further, we must be sure that existing contract provisions are being implemented.

"Some experts have estimated that hospital costs will rise by 16 to 17 percent if economic controls are allowed to expire and new cost controls are not adopted."

Sheppard said, "Since controls over physicians' fees will also be lifted, Pennsylvania Blue Shield must take positive steps to monitor the fees charged its subscribers.

"Working together; Blue Cross, Blue Sheild, hospitals, doctors and State government can keep the costs of health care under control while seeing to it that quality care continues to be provided to the people of Pennsylvania," Sheppard said.

Exhibit 17

HOSPITAL AGREEMENT
July 1, 1971
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HOSPITAL AGREEMENT
July 1, 1971

The undersigned hospital (hereinafter called the "Provider") and Blue Cross of Greater Philadelphia (hereinafter called "Blue Cross") in entering this Agreement reaffirm their intent to provide a planned, innovative and efficient health care delivery system to meet the medical needs of the communities they serve. As part of its undertaking, Blue Cross agrees on behalf of each subscriber to the Hospitalization Plan of Blue Cross, Health Service, Incorporated, or other Hospital Service Plan as designated and approved by Blue Cross (hereinafter called "Subscriber") to make those payments required hereinafter and provide its assistance to all area health care institutions in developing procedures and practices to further the goal of a consumer-responsive health care delivery system. The Provider agrees to utilize its best efforts to provide a viable and economical health care delivery system to satisfy the medical needs of the community which it serves.

In order to accomplish the foregoing objectives, the parties hereto, intending to be legally bound, do hereby agree as follows:

Section 1. Provider Services and Facilities.

In consideration of the agreement by Blue Cross to reimburse the Provider as hereinafter described, the Provider agrees:

1.1. To furnish, as applicable, to each Subscriber those hospital services and facilities whereby there may be administered certain medical services incident to hospitalization of the type which Blue Cross is obligated to provide Subscribers (hereinafter called "Covered Services").

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1.2. That Covered Services shall be available to each Subscriber beginning with the effective date of his Subscription Agreement with Blue Cross (hereinafter called "Subscription Agreement"), except that any waiting periods specified therein may be modified or waived by Blue Cross in such cases as it may determine.

1.3. The Covered Services shall be provided each Subscriber without an advance deposit or charge therefor to the Subscriber except to the extent of any co-payment or deductible amount provided in his Subscription Agreement, including all Form 11 Subscription Agreements (as defined in subsection 1.3.1(d) of Exhibit A hereto), and that, except as aforesaid, Provider will accept the reimbursement provided for herein as the full contract payment of Blue Cross for such Covered Services.

1.4. That its charges for all services to Subscribers shall be the same as its charges to all patients for the same services. The Provider shall file a current schedule of such charges with Blue Cross and furnish written notice to Blue Cross of any modification of such charges at least five days prior to the effective date of such modification. Provider shall also deliver to Blue Cross a copy of the documents required by the policy regulations of the federal Price Commission to be filed with the Medicare intermediary as such relate to any modification in its schedule of charges.

Section 2. Reimbursement by Blue Cross.

Blue Cross agrees to reimburse the Provider for Subscriber admission on or after the effective date of this Agreement for those Covered Services furnished to Subscribers upon receipt of the medical records, if requested, and bills therefor, as follows:

2.1. Reimbursement will be made in accordance with the terms and conditions set forth in Exhibit A attached hereto and made a part hereof, except as otherwise provided herein.

2.2. If Covered Services are furnished as stated dollar allowances or indemnities, except for private room accommodation and indemnities for certain services of physicians, payment of such allowance or indemnity shall constitute final payment by Blue Cross and such Covered Services shall be excluded from any reimbursement calculation required by Exhibit A hereof although such reimbursement shall not preclude Provider from collecting the balance of its charges for such Covered Services from Subscribers.

2.3 If any hospital admission on or after the date of execution hereof, which would otherwise have been Covered Services, is ultimately determined to be medically unnecessary as a result of formal medical review, the Provider shall not charge either Blue Cross or the Subscriber for such an admission. For the purposes of making the foregoing determination, Blue Cross shall advise the Provider's Utilization Review Committee of any case which it has determined to have been medically unnecessary. If the Utilization Review Committee concurs with Blue Cross, such determination will be deemed conclusive unless the physician appeals or if upon review the representatives of Blue Cross and Provider's Utilization Review Committee cannot reach a mutually agreeable result as to a given case, then such case shall be referred, at the expense of Blue Cross, to the appropriate committee of the Philadelphia County or State Medical Society (or such county committee as shall hereafter be created and approved by the Provider and Blue Cross), as applicable, for its determination as to the medical necessity for the

aforesaid hospital admission. It is agreed that the determination of such medical society shall be binding on both Blue Cross and Provider. If a given hospital admission was determined to have been medically unnecessary as a result of the foregoing review procedure, but medically necessary services were furnished which should have been provided on an outpatient basis, Blue Cross shall reimburse Provider for any such Covered Services on an outpatient basis to the extent provided in the Subscriber's Subscription Agreement. However, if the Subscriber insists on hospitalization against the advice of his physician, the Provider may charge any unreimbursed charges to the Subscriber, provided, the Provider has supplied appropriate written evidence to Blue Cross that the Subscriber has been advised of his financial responsibilities.

Section 3. Effective Date.

The provisions of this Agreement are applicable only to Subscriber admissions on or after July 1, 1971 (sometimes referred to herein as the "effective date of this Agreement") and all previous payments made by Blue Cross to the Provider under any superseded contract for such admissions shall be considered to be advance payments subject to the adjustments made necessary by this Agreement.

Section 4. Calculation of Inpatient Days.

4.1. *Inpatient day defined.* For purposes of this Agreement an inpatient day begins at midnight and ends twenty-four hours later. The midnight-to-midnight method is to be used in reporting days of care for Subscribers, even if the Provider uses a different definition of inpatient day for statistical or other purposes.

A part of a day, including the day of admission, counts as a full day. However, the day of discharge or a

day on which a patient begins a leave of absence is not counted as a day, but this limitation does not apply to covered ancillary services on the day of discharge. If admission and discharge occur on the same day, such day is considered a day of admission and counts as one inpatient day.

4.2. *Late discharge.* If a Subscriber continues to occupy his accommodations beyond the Provider's regular discharge hour, after being advised prior to such discharge hour that further hospitalization is not required, the Provider may charge the Subscriber for his continued stay. However, if the Subscriber's physical condition is the cause of the stay beyond the Provider's regular discharge hour, the Provider may not charge the Subscriber for Covered Services.

4.3. *Leave of absence.* The day on which a Subscriber begins a leave of absence shall be treated as a day of discharge and not counted as an inpatient day unless he returns to the Provider by midnight of the same day. The day the Subscriber returns to Provider from a leave of absence is treated as a day of admission and counted as an inpatient day if he is physically present at midnight of such day.

4.4. *Limited number of days.* If the Subscription Agreement provides a limited number of days for certain surgical cases, the day on which the operation is performed is included in the days allowed to the Subscriber under the Subscription Agreement.

Section 5. Accommodations.

Semiprivate accommodations including routine general services, which term shall mean accommodations having two, three or four beds per room, are Covered

Services for which the Provider shall be entitled to be reimbursed as determined in accordance with the terms of this Agreement. When accommodations other than semiprivate are furnished, reimbursement for such will be adjusted in the following manner:

5.1. Private Rooms Medically Necessary.

5.1.1. Private rooms or other accommodations including intensive care and other specialty service facilities more expensive than semiprivate will be Covered Services only when such accommodations are medically necessary. Such accommodations shall be considered medically necessary when the attending physician has noted on the Subscriber's medical chart that the Subscriber's condition requires that he be isolated for his own health or that of others.

5.1.2. Isolation may be necessary when treating certain communicable diseases in order to avoid cross-infection, as well as other physical and mental conditions when privacy is necessary for patients whose symptoms or treatment are likely to alarm or disturb others in the same room.

5.2. Private Rooms Not Medically Necessary.

5.2.1. When accommodations more expensive than semiprivate are furnished the Subscriber at the time of admission because less expensive accommodations are not available, Blue Cross will reimburse the Provider on the same basis as is applicable to semiprivate accommodations.

5.2.2. When accommodations more expensive than semiprivate are furnished the Subscriber at his request and in the absence of medical necessity, the Provider may charge the Subscriber for the difference between the

charges for the accommodations furnished and the credit for those accommodations included in Covered Services. No such charge may be made to the Subscriber unless he requested the more expensive accommodations with knowledge that he would be charged the differential.

5.3. Wards.

5.3.1. When ward accommodations, which term shall mean five or more beds per room, are furnished the Subscriber at his request, or when semiprivate accommodations are not available at the time of his admission, reimbursement shall be made on the same basis as is applicable to semiprivate accommodations. However, it is understood and agreed that the Subscriber must be moved to semiprivate accommodations when they become available unless the Subscriber specifically requested ward accommodations at the time of his admission.

5.3.2. When ward accommodations are furnished neither at the Subscriber's request, nor due to the lack of available semiprivate accommodations, the reimbursement for ward accommodations shall be on the same basis as is applicable to semiprivate accommodations minus a "ward differential" which shall be computed by calculating the difference between the Provider's customary charges for semiprivate accommodations at its most prevalent rate (the rate which applies to the greatest number of semiprivate beds) in effect at the time of the Subscriber's admission and the charge customarily made for the ward accommodation furnished the Subscriber.

5.3.3. For purposes of administration, when ward accommodations are furnished not at the Subscriber's request, or due to the lack of available semiprivate accommodations, for a period exceeding three days, the entire admission shall be considered a ward admission

and all days charged for this admission shall be adjusted in the manner described in subsection 5.3.2 above. However, when ward accommodations are initially furnished because semiprivate accommodations are unavailable and the Subscriber is subsequently moved to a semiprivate accommodation within three days following the date of admission, the entire admission shall be considered to be semiprivate.

5.4. Specialty Service Facilities.

Reimbursement for the use of intensive care facilities and other specialty service facilities will be made in accordance with subsection 5.1 when such are medically necessary, except where explicitly excluded from Covered Services by the applicable Subscription Agreement.

Section 6. Provider Employees and Private-Duty Nursing.

The reasonable cost of Covered Services rendered by all personnel engaged by the Provider (either on a salary or fee-for-service basis), under arrangements which provide for billing to be made by the Provider, shall be included as a reimbursable cost hereunder.

The cost of private-duty nurses or private-duty attendants (registered professional nurses, licensed practical nurses, or any other trained attendants) whose services are rendered to and restricted to a particular Subscriber by arrangement between the Subscriber and the private-duty nurse or attendant is not reimbursable hereunder.

Section 7. Covered Services Obtained from Outside Sources.

In order to avoid unnecessary duplication of services, the Provider shall institute procedures whereby Covered Services, including timely tests and other timely diagnostic and therapeutic procedures, performed by outside

sources such as pathologists, radiologists and other hospitals, which are licensed pursuant to applicable state regulation, meet the Provider's established quality standards and have been approved by the Provider, will be accepted for use in rendering patient care. Provider shall institute such procedures as may be required for the reasonable regulation of its medical staff directed toward the continued concentration of these tests within its facilities so as to prevent undue escalation of Provider's unit cost for such services. Except for those certain medical services incident to hospitalization provided for in Section 10 hereof, the Provider may not allow those furnishing Covered Services to bill the Subscriber for such services.

Where Covered Services are obtained for Subscribers from such outside sources, reimbursement hereunder shall be made on the basis as though such Covered Services were performed by the Provider. The costs to the Provider shall be used as the reasonable charges for the Covered Services and shall be the amount included in the Subscribers' bills submitted to Blue Cross by the Provider.

Notwithstanding the foregoing, in those cases where the Provider has consolidated any of its ancillary services with those of another health care institution, reimbursement for the Covered Services there performed shall be on the same basis as if such services had been rendered through the Provider's own facilities.

Section 8. Physician Recommendations.

Covered Services shall be rendered to a Subscriber only upon the recommendation of a physician who is a member of the medical staff of, or acceptable to, the Provider and shall continue only during such period as the Subscriber is in need of hospital care for the treatment of illness or bodily injury and is under the care of such a physician.

Section 9. Medical Staff Privileges.

If the Provider is a medical school hospital, the Provider agrees to maintain the standards for staff appointment established by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association, as applicable, and the Provider shall grant appropriate medical staff privileges to qualified physicians on the staffs of those hospitals with which it maintains educational affiliations.

Section 10. Arrangements Between Providers and Physicians.

10.1. Reimbursement by Blue Cross.

The Provider and physicians rendering those certain medical services provided for herein may commence, continue, revise or terminate arrangements between them for these services as in their discretion they see fit. In determining reimbursement pursuant to Exhibit A, Blue Cross will recognize the applicable arrangements prevailing between the Provider and such physicians who render certain covered medical services when incident to the hospitalization of Subscribers as provided hereunder.

10.1.1. Under such arrangements when the bills for such covered medical services are included in the Provider's bills rendered to all patients, the compensation paid to physicians rendering those services shall be included as a part of the Provider's cost of those services. After the allocation of costs in accordance with subsection 2.3 of Exhibit A, Part I, the determination of cost of Covered Services to Blue Cross Subscribers shall be made in accordance with subsection 2.2 of Exhibit A, Part I. Blue Cross will pay the Provider the cost of such covered medical services as determined above, thereby

indemnifying the Subscriber against such bills, and in addition will pay to the Provider the amount otherwise payable to the Provider hereunder for the hospital services rendered by it.

10.1.2. Under such arrangements when the bills for such covered medical services are billed directly to all patients by such physicians, Blue Cross shall make payment directly to the party submitting such bills to it of the reasonable and customary charges for such covered medical services within the limits of the Subscription Agreement, thereby indemnifying the Subscriber against such bills.

The Provider also may have incurred unreimbursed cost in providing the facilities for the rendering of such covered medical services. After the allocation of these costs, if any, in accordance with subsection 2.3 of Exhibit A, Part I, the determination of inpatient cost of Covered Services to Subscriber shall be made in accordance with subsection 2.2 of Exhibit A, Part I, if the Provider has either: (a) complete information with respect to the regular charges for those certain medical services for both Subscribers and all other patients who receive the services; or (b) complete information with respect to regular charges of the Provider made in connection with the rendering of the certain medical services for both Subscribers and all other patients who receive the services. In the event the information required in (a) or (b) above is not available to the Provider, the determination of inpatient cost of Covered Services to Subscribers shall be made as follows: (i) on total occasions of such inpatient medical service or a statistical basis of allocation approved for such use in Title XVIII of Public Law 89-97 (hereinafter called "Medicare") apportioned between Subscribers and other patients; or, if this information is not

complete, (ii) on total inpatient admissions apportioned between Subscribers and all other patients. Blue Cross will pay to the Provider the cost of such covered medical services as determined above and in addition will pay to the Provider the amounts otherwise payable to the Provider hereunder for the hospital services rendered by it.

10.1.3. Under such arrangements when the bills for any one of the certain medical services incident to hospitalization are included in the Provider's bill rendered to some patients, and when bills for such medical services are billed directly to some patients by such physicians, Blue Cross shall make payment directly to the party submitting such bills to it as are billed directly by such physicians, of the reasonable and customary charges for such covered medical services within the limits of the Subscription Agreement, thereby indemnifying the Subscriber against such bills. The Provider's cost of such medical services shall be subdivided into those applicable to services billed for by the Provider and those applicable to services billed for by the physician. The cost of covered medical services for each of these categories shall then be determined in accordance with the methods described in subsections 10.1.1 and 10.1.2 above, as appropriate. Blue Cross will pay the Provider its cost as so determined.

10.1.4. Under such arrangements when the bills for certain medical services incident to hospitalization have been billed directly to patients by such physicians, the Provider may have incurred cost in providing the facilities for the rendering of such covered medical services in return for an agreed upon payment by the physiciar to the Provider. Payments received by the Provider under such an arrangement shall be treated as a reduction of allowable cost of the Provider to the extent of such cost.

10.1.5. In the event the Provider has elected to be reimbursed on a prospective rate basis in accordance with Part II of Exhibit A, the Provider agrees that: (a) the amounts payable directly to physicians by Blue Cross under subsections 10.1.2 and 10.1.3 above shall be excluded in the determination of such gross prospective rate; (b) the amounts otherwise payable by Blue Cross to the Provider for costs the Provider may have incurred in providing the facilities for rendering such medical services pursuant to subsections 10.1.1, 10.1.2 and 10.1.3 above shall be incorporated in the determination of such gross prospective rate and no additional payment will be made by either Blue Cross or the Subscriber; and (c) the payments received by the Provider pursuant to subsection 10.1.4 shall be deducted in making the determination of such gross prospective rate otherwise payable to the Provider by Blue Cross. To ensure that the gross prospective rate adequately reflects the costs to Provider of the various arrangements which it has with physicians rendering such covered medical services, Provider shall notify Blue Cross of any modification or amendments to such arrangements and in such events Blue Cross will make appropriate changes in the gross per diem rate.

10.2. Reporting Requirements.

The Provider shall report annually to its governing board or a committee thereof the actual compensation or if unknown, an estimate, received by each of the anesthesiologists, pathologists and radiologists on its staff for services to the Provider's inpatients and outpatients.

Section 11. Utilization Review.

11.1. The Utilization Review Program.

11.1.1. The Provider shall maintain or create and maintain, as appropriate, a program of utilization review

which shall be implemented by a Utilization Review Committee whose membership shall include the Provider's Administrator or his designee, and at least one non-physician member of its governing board.

11.1.2. The Provider shall forward to Blue Cross a copy of the Utilization Review Plan which it has previously filed with the appropriate state agency and as such Plan is changed or modified shall advise Blue Cross accordingly.

11.1.3. The Provider will strive to improve the effectiveness of its Utilization Review Plan by exerting special efforts in reviewing:

(a) Lengths of stay;

(b) Promptness of service;

(c) The medical necessity of admissions;

(d) Use of consultations;

(e) Implementation of effective discharge planning; and

(f) Such other efforts and procedures as will minimize unnecessary use of expensive medical resources and ensure proper patient care.

11.2. Review of Admissions.

The Provider shall have all elective cases reviewed within 72 hours [excluding Saturdays and Sundays] following the patient's admission and establish an expected length of stay for each such case based on the admission diagnosis. Any variations between such established and experienced length of stay shall be investigated by the Utilization Review Committee. Non-elective cases will be reviewed by the Utilization Review Committee on a biweekly basis.

11.3. Reporting Procedures.

In the event Provider does not subscribe to the Hospital Utilization Project (HUP), Professional Activity Study (PAS) or similar reporting service, Blue Cross shall furnish to the Provider data indicating the average lengths of stay for the most frequent diagnoses in this general geographic area and a quarterly listing, itemized by diagnosis, of the Provider's experienced length of stay for Subscribers. If any quarterly study of HUP, PAS or Blue Cross supplied data indicates that the Provider's experienced average length of stay for any major diagnosis is more than ten percent longer than the area average, the Utilization Review Committee shall determine the basis for this variance and submit a written explanation of the causes with suggested corrective measures to its governing body, with a copy of this report being forwarded to Blue Cross. All comparisons required above shall be made with reference to data for patients under age 65.

11.4. New Services.

Any additional cost which Provider incurs as a direct result of an expansion, increase or modification of its existing services in order to satisfy the requirements set forth in subsections 11.2 and 11.3 shall be a reimbursable cost hereunder and treated as a new service as provided for in subsection 18.4.2 hereof.

Section 12. Cost Saving Programs.

Provider shall, to the extent practicable, actively participate on a continuing basis in the following Blue Cross programs or equivalent programs approved by Blue Cross which seek to encourage the effective use of Provider's inpatient facilities: (a) preadmission testing, (b) short procedure unit, (c) home care service, and (d) planned discharge.

Section 13. Systems Analysis.

In order to provide a means whereby more efficient methods of operation may be developed and implemented, the Provider shall assign one or more administrative employees the responsibility for systems analysis directed toward accomplishment of this objective.

Section 14. Use of Modern Management Techniques.

14.1. The Provider may during the term of this Agreement undertake a comprehensive study of its operating and administrative procedures utilizing one or more independent consulting agencies to assure an optimal organizational structure and fix staffing levels for each of its departments, using objectives acceptable to both the Provider and Blue Cross. Further, it is agreed that any such study may be undertaken with other hospitals on a joint basis, and if the Provider has commenced or is continuing any such study, said study will satisfy the terms of this Section for the periods subsequent to July 1, 1971 if it has received the approval of Blue Cross. The cost of any such study shall be included in the operating costs of the Provider which are reimbursable in accordance with this Agreement for the applicable fiscal year in which payments are made.

14.2. If the study described in subsection 14.1 above is initiated by Provider, or other general or special management studies are undertaken which are determined by Blue Cross to be consistent with this Agreement, and if initial implementation of the recommendations produced by such study is commenced within six months immediately following the date of such recommendations, Blue Cross will make an unrestricted grant separate and apart from any other reimbursement required by this Agreement, based on the total cost of such study up to

$100 per bed annually ($300 per bed annually in the case of general management studies). The foregoing grant shall be in a sum equal to the amount obtained by determining the maximum allowable per diem cost of the study applicable to all inpatient days during such fiscal year which have been provided to other than free and part-pay patients and multiplying such allowable per diem cost by the number of Blue Cross inpatient days provided during the applicable fiscal period.

14.3. In order to ensure that the recommendations of the foregoing studies are available for use by other health care institutions seeking to develop cost-saving programs, the Provider shall furnish to Blue Cross on a scheduled basis a summary of all reports and relevant data regarding the results and implementation of its studies so that such information may be periodically distributed to other area hospitals.

Section 15. Modification of Reimbursement.

The Provider and Blue Cross agree that reimbursement for Covered Services by Blue Cross will be for services of high quality furnished as efficiently and economically as possible, and paid for in the most effective and equitable manner that can be devised. In recognition of this objective, the parties hereto agree that reimbursement hereunder may be modified by the mutual agreement of the Provider and Blue Cross. Any such modified reimbursement shall become effective for admissions on and after the first of the month next following such modification, or as soon thereafter as reasonably possible.

Section 16. Generic Equivalents.

16.1. If the Provider has on its staff a full-time pharmacist, it shall maintain a Drug Formulary Committee either of its own, or in cooperation with area hospitals, which will develop and implement a program designed to ensure that drugs are dispensed by generic rather than brand name when the less expensive generic equivalent is available. As part of this program, Provider will utilize prescription blanks which contain a printed legend authorizing the pharmacy filling the prescription to dispense, when available, generic equivalents for the brand name drugs prescribed.

16.2. In developing the drug formulary program, it is recognized that in certain situations it may be necessary and prudent for the prescribing physician to designate a specific brand name drug due to compounding differences in the generic equivalent. To allow for these unusual situations, the Provider may make suitable internal arrangements provided the physician requiring such brand name drugs makes an appropriate notation on the patient's medical chart or similar record. The Provider shall maintain in sufficient detail suitable records and other data which will be reviewed by the Drug Formulary Committee and made available for inspection by Blue Cross.

Section 17. Cooperation Between the Provider and Blue Cross.

The Provider and Blue Cross agree to cooperate fully with each other in administering the various provisions of this Agreement. To this end, Blue Cross shall promptly furnish Provider such information as is necessary to verify the payments made to it by Blue Cross. Blue Cross shall submit to the Provider upon request: (a) monthly financial reports of its operations and its current balance sheet position; (b) annual financial balance sheets and income and surplus statements as certified by independent accountants within thirty days after the receipt thereof

from the accountants; and (c) copies of all transactions and financial operating data having a bearing on this Agreement. Similarly, Provider shall submit to Blue Cross all cost information regarding its operations which is necessary for the administration of this Agreement, and will permit Blue Cross to examine and audit all records, documents, and financial and statistical data which may relate to reimbursable costs as determined herein.

Section 18. Budgetary Review Procedures.

18.1. Submission of Budgets.

Provider shall submit its annual budget to Blue Cross at least forty-five days prior to the first day of Provider's fiscal year on the standard form which is attached hereto as Exhibit B, as such may be modified from time to time. The budget shall include a proposed gross inpatient per diem rate for interim payments by Blue Cross to Provider. The budget as submitted to Blue Cross shall have had the prior approval of Provider's Budgetary Committee or similar financial committee, the membership of which shall include at least one member of Provider's governing body. For Provider's first fiscal year under this Agreement, the foregoing requirement may be satisfied by submission of Provider's budget in its own format with comparative information in such reasonable detail as is necessary to distinguish inpatient and outpatient costs, determine the effects of any wage-price stabilization policies on anticipated costs in the budgeted year, and permit line comparisons with previous years' budgets and financial results of operations as soon as reasonably possible after the execution of this Agreement, but in no event later than 30 days after the execution hereof. The budgets submitted in accordance with this subsection 18.1 shall include all adjustments made necessary by the application of federal price stabilization requirements.

18.2. Interim Payments.

Blue Cross shall review the data submitted by Provider to determine the reasonableness of the expenses included therein in accordance with the provisions contained in Exhibit A hereof utilizing the following procedures:

18.2.1. If Blue Cross shall determine that the estimates set forth in the budget submitted by the Provider are reasonable within the meaning of subsection 2.1 of Exhibit A, Part I hereof, Blue Cross shall so advise the Provider and use the gross inpatient interim per diem rate proposed by Provider for admissions during such budgeted fiscal year.

18.2.2. If Blue Cross determines that the cost estimates included in Provider's budget as submitted are unreasonable, or that the gross inpatient interim per diem rate proposed by Provider has not been properly computed, Blue Cross shall within forty-five days of its receipt of said budget so advise Provider and request a meeting with Provider's representatives to review the matter and determine whether appropriate modifications should be made in the budget or the gross inpatient interim per diem rate. If Blue Cross does not so advise Provider within the aforesaid forty-five day period, Blue Cross shall reimburse Provider based on the gross inpatient interim per diem rate proposed by Provider until such time as a meeting can be held to review the reasonableness of Provider's budget.

18.2.3. If Provider and Blue Cross are unable to reach agreement as to the reasonableness of the budgeted costs, Blue Cross shall determine the gross inpatient interim per diem rates for the budgeted year based upon its review and findings, considering any supplemental data submitted by Provider. In such event, Provider may exercise its

right of appeal as set forth in Section 21 hereof, accepting the interim rate set by Blue Cross until a final decision is rendered by the Appeals Board or Court, as appropriate. However, it is expressly understood by the parties hereto that the foregoing right of appeal shall pertain only to gross inpatient interim per diem rates as determined above and does not extend to any rate fixed pursuant to subsection 18.5.

18.2.4. When the gross inpatient interim per diem rates have been based on unaudited data, such rates shall be subject to appropriate increase or decrease retroactively and prospectively if the net audit adjustments, excluding non-recurring items, amount in aggregate to more than one dollar ($1.00) per patient day subject to the limitations contained in subsection 18.4.

18.2.5. All gross inpatient interim per diem rates established pursuant to this Agreement shall be subject to review and adjustment in the event a major unforeseeable and unanticipated cost increase or decrease occurs during the fiscal year, in which case the Provider shall so advise Blue Cross promptly of such changes and forward to Blue Cross the appropriate supporting data.

18.3. Quarterly Reports.

Provider shall submit quarterly to Blue Cross its statement of current operating costs within seven days following the date when such are reviewed by its governing board or financial committee. The statement as submitted to Blue Cross shall show the actual operating experience of Provider with budget comparisons for such period.

18.4. Limitation on Reimbursement.

The reimbursement to be paid Provider by Blue Cross as either an interim rate or pursuant to the auditing

procedure set forth in Exhibit A shall be subject to the following limitations for the fiscal year 1971-72:

18.4.1. Subject to subsections 18.4.3 and 18.4.4 hereof, the maximum total allowable cost, upon which Blue Cross reimbursements to the Provider shall be based, for the fiscal year 1971-1972 shall be limited to 112% of the actual total allowable costs of the Provider approved by Blue Cross for the fiscal year 1970-1971.

18.4.2. In calculating the maximum total allowable cost of the Provider for the fiscal year 1971-1972, such computation shall exclude the cost of the joint study provided for in subsection 1.4.6 of Exhibit A, Part I and all depreciation allowances applicable to the 1970-1971 and 1971-1972 fiscal periods, and shall make appropriate additions or reductions in the fiscal 1970-1971 cost to reflect changes in services or facilities initiated or deleted by the Provider so as to annualize the two periods for comparison purposes.

18.4.3. The maximum total allowable cost to be permitted Provider under this Agreement may be adjusted for unanticipated cost amounting in the aggregate to more than ten cents ($0.10) per patient day (including payments by Provider required by Sections 14 and 24 as well as the cost associated with implementing the recommendations of studies made pursuant to Section 14 hereof) when such cost (a) is beyond the control of Provider or is required by an accrediting body or governmental agency, (b) was not foreseeable at the time the annual budget was submitted to Blue Cross, and (c) is adequately demonstrated by appropriate records of the Provider.

18.4.4. In the event arrangements between the Provider and physicians rendering covered medical services as described in Section 10 hereof are initiated, modified,

revised or terminated with the result that the Blue Cross payments to Provider for such covered medical services are modified, the 1970-1971 approved cost used in calculating the maximum reimbursement for purposes of subsection 18.4.1 shall be adjusted accordingly.

18.4.5. In the event the Provider determines it is unable to maintain its cost as computed in accordance with Exhibit A hereof within the maximum limitation established by this subsection 18.4, the Provider may elect to terminate this Agreement upon providing Blue Cross fifteen days prior written notice of such intent to terminate. In such case the obligations set forth in Section 27 shall apply and the interim payments provided for herein shall be continued at the rate then in effect subject to such modification as any subsequent contract may require.

18.4.6. The limitation on total allowable cost, if any, for 1972-73 will be negotiated during the six month period immediately prior to July 1, 1972. In determining any such subsequent limitation it is agreed that the information supplied by Provider pursuant to subsection 18.1 shall serve as the basis for such negotiations. If agreement is not reached by July 1, 1972 this Agreement shall terminate as of such date subject to Section 27 hereof.

18.5. Prospective Rating.

Provider may elect in lieu of the reimbursement otherwise payable by Blue Cross under this Agreement to negotiate a fixed inpatient per diem rate of reimbursement which shall be payable no less frequently than semimonthly to the Provider by Blue Cross. Such fixed rate will be determined to the mutual satisfaction of the parties hereto, based on the Provider's budget as submitted in accordance with subsection 18.1 hereof and the 1970-1971 per diem cost as approved by Blue Cross using

as the basis for such determination the projected costs as developed from application of the Principal set forth in Part I of Exhibit A.

In fixing such a prospective rate, the limitations set forth in subsection 18.4 hereof, and subsection 1.4 of Exhibit A, Part I, as applicable, will provide a ceiling for such rate. If there is a change in the arrangements described in Section 10 hereof, an appropriate concurrent change in the prospective rate will be made. Moreover, it is agreed that such rate will not be subject to review or appeal pursuant to Section 21 and the Provider will be permitted to retain for improvement of services all overage received by achieving a cost which is below the prospective rate or be required to absorb any deficiency if during the appropriate fiscal period its costs should exceed payments received under the negotiated prospective rate.

Any grants, other than mere reimbursement for expenses incurred, to be made to Provider by Blue Cross in accordance with Section 14 of this Agreement shall be separate and apart from the amounts to be paid pursuant to this subsection 18.5. All prospective rates shall reflect the effect of any wage-price freeze on hospital budgets and costs so as to satisfy all applicable federal price stabilization requirements and, where made necessary by the occurrence of any unanticipated and unforeseeable happening, be adjusted in accordance with subsection 18.4.3.

Section 19. Purchasing Procedures.

Provider's governing board, or a committee thereof, shall review the practice and procedures of its purchasing officers and agents to insure that the "Prudent Buyer Concept" is employed when making purchases of equip-

ment, supplies and services. The reports and statistical data used by the purchasing officers and agents shall be made available to Blue Cross for review.

Section 20. Professional Liability-Safety Control Program.

In order to maintain a comprehensive program of loss control and loss prevention, the Provider shall establish or maintain, as applicable, a safety program based on the American Hospital Association's "Hospital Safety Manual" and incorporating the principles set forth in Exhibit C attached hereto and made a part hereof.

Section 21. Right of Appeal.

21.1. In the event of any disagreement between the parties hereto concerning the application, operation or interpretation of this Agreement, other than as expressly excepted herein, either party hereto shall have the right to refer the matter to an Appeals Board composed of three or five members as specified in the written notice of the Appellant initiating the appeal (except that if such notice specifies three members the answer of Appellee may increase the number to five). The notice of appeal shall name Appellant's representative to the Board and the answer of Appellee shall name its representative to the Board. If the answer of Appellee is not served on Appellant within two weeks after Appellee's receipt of the notice of appeal, Appellee's representative shall, at the request of Appellant, be named by the President Judge of the Court of Common Pleas of the county where Provider is located, or such other judge of that court as he shall designate. The representatives of Appellant and Appellee shall promptly meet and select the other members of the Appeals Board. If they fail to make such selection within thirty days of the designation of Appellee's representative, the selection of the other members shall be similarly made by such President Judge or a judge of that court designated by him. The cost associated with the foregoing appeals procedure shall be borne equally by the parties thereto and the Provider's share of such cost shall be included as a reimbursable cost hereunder, provided, however, that the Appeals Board shall have the power to determine whether the Provider has been unreasonable in forcing the disagreement to arbitration, and if so, the Appeals Board may or may not exclude all or any part of the Provider's share of such cost as a reimbursable cost hereunder.

The Appeals Board shall conduct a formal hearing as to the matters set forth in the notice of appeal and thereafter forward its adjudication to the Provider and Blue Cross within sixty days after the hearing is closed. The adjudication shall be in writing and signed by the majority of the Board members hearing such appeal. If within thirty days after receipt of the Board's adjudication either party is aggrieved thereby, it shall have the right to appeal such adjudication to the appropriate court of competent jurisdiction which shall hear the case *de novo*. In the event an appeal is taken within the aforesaid thirty day period, such appeal shall operate as a supersedeas without further action by the appeals court or the parties hereto.

21.2. No action at law or in equity in connection with the application, operation or interpretation of this Agreement shall be instituted by either party until it has exhausted the right of appeal hereunder. In addition, no action at law or in equity shall be maintainable by either party to this Agreement against the other party hereto for any claim arising out of this Agreement unless such action be brought within two years from the date when the

cause of action arose, provided, however, that this limitation shall not preclude the appeal provided for in subsection 21.1.

Section 22. Status of Provider and Blue Cross.

22.1. The Provider hereby represents that it is a nonprofit institution approved by either the Joint Commission or Accreditation of Hospitals or the Bureau of Hospitals of the American Osteopathic Association and as such is approved or duly licensed as required by state law. If the Provider's status or method of operation changes during the term of this Agreement it will immediately notify Blue Cross of such change.

22.2. Blue Cross hereby represents that it is a corporation duly organized and existing under the laws of the Commonwealth of Pennsylvania for the purpose of operating a nonprofit hospitalization plan and is licensed to use the Blue Cross name and insignia. If Blue Cross' status or method of operation changes during the term of this Agreement it will promptly notify the Provider of such change.

Section 23. Accreditation.

In order to encourage the Provider to satisfy recognized minimal standards in providing patient care, Provider agrees to strive for accreditation by the Joint Commission on Accreditation of Hospitals or the Bureau of Hospitals of the American Osteopathic Association. In the event the Provider is not so accredited Blue Cross shall have the right, notwithstanding any other provision contained herein, to terminate this Agreement upon giving the Provider thirty days prior written notice of such intent to terminate.

Section 24. Planning of Health Care Facilities.

24.1. Major Construction of Facilities.

If the Provider undertakes any project for the replacement or expansion of its facilities and equipment at an estimated cost in excess of $250,000, it will submit such project to the Hospital Survey Committee, Inc., ("HSC") for review prior to the letting of contracts therefor.

24.2. Expansion of Certain Services.

If the Provider undertakes a project to provide either a new service listed below or expand an existing service listed below in such a way as to require in any one fiscal year additional space (beyond that theretofore used for such service) greater than 10% of the space theretofore so used, it will submit such project to HSC for review prior to the letting of contracts therefor. The services referred to in this subsection are the following: (a) megavoltage radiation services; (b) open-heart surgery services; (c) obstetrical services; (d) pediatric services; (e) operating room services; (f) emergency care services; (g) diagnostic radiological services; (h) hemodialysis services; (i) burn treatment services; (j) other services acceptable to Provider as criteria are developed by HSC.

24.3. Change of Function.

In addition to the requirements set forth in subsections 24.1 and 24.2 hereof, if Provider has obtained the prior endorsement of HSC for a given facility and desires within three years of such endorsement to change the function of such facility or a substantial portion thereof, it shall submit and obtain the endorsement of HSC for such change prior to the implementation thereof.

24.4. Denial of Reimbursement.

If HSC refuses to endorse a project reviewed by it pursuant to subsections 24.1, 24.2 or 24.3 within 90 days after it has received all pertinent data requested by it from the Provider and the Provider, nevertheless, carries out the project, Blue Cross reimbursement to the Provider will be calculated before any allowance for depreciation or interest expense with respect to the facilities of such project as to subsections 24.1, 24.2 and 24.3 or the services supplied by such project with respect to subsection 24.2. If a project is submitted for HSC endorsement which HSC considers not within the purview of this Agreement, it shall so advise the Provider within 90 days of such submission and this subsection 24.4 shall not apply to such project.

24.5. Periodic Evaluation; Elimination of Facilities.

The Provider shall permit HSC to evaluate once every three years, but only at a time when Provider is bound by a contract containing substantially the same provisions as this Section 24, the need for existing facilities of, and services supplied by, the Provider. The evaluation shall cover facilities which do not conform to the then current requirements for new construction in respects which render them unsafe for patients. If the report of HSC as submitted to Blue Cross and the Provider recommends that a facility or a service of Provider is no longer needed, it shall specify a reasonable time period by the end of which the facility or service must be eliminated. Similarly, if the report states that a facility is unsafe, it shall specify a reasonable time period by the end of which the facility must be made safe or eliminated. After the end of a period so specified, Blue Cross reimbursement to the Provider shall be calculated without any allowance for the cost of facilities or

services not eliminated or made safe in accordance with such evaluation, unless Provider is expressly prohibited from eliminating such facilities or services by law.

24.6. Agreement for the Financing of the Activities of HSC.

HSC has agreed to perform the services described in Section 24 "Planning of Health Care Facilities", for the period January 1, 1972 to June 30, 1973 in consideration of the amount of $620,000. The Provider agrees to pay its proportionate share of this $620,00 cost and Blue Cross agrees that the Provider's proportionate share of this expense shall be included in the Provider's total allowable cost in the amount incurred for each fiscal year, or portion thereof.

24.6.1. Provider's proportionate share of the total cost of services to be performed by HSC pursuant to this Agreement shall be determined first as a percentage by dividing the Provider's total allowable cost by the total aggregate allowable costs of all Providers contracting with Blue Cross participating in "Planning of Health Care Facilities." Such percentage shall then be applied to the $620,000 total cost of the services of HSC to determine the dollar amount of each Provider's proportionate share. The total allowable costs for the fiscal year 1969-1970 shall be used in determining the Provider's proportionate share.

24.6.2. Method of Payment.

To provide HSC with the cash flow necessary to provide the services detailed in this Agreement from one source and to eliminate an adverse effect on the Providers' cash flow during any fiscal year, Blue Cross shall on the behalf of all Providers contracting with Blue Cross and participating in "Planning of Health Care Facilities,"

pay monthly to HSC an amount equivalent to 1/18 of each Provider's proportionate share of the agreed $620,000 which sum represents the total cost of the service for the 18 month period January 1, 1972 to June 30, 1973.

Blue Cross shall advise each Provider as to the amount and date of all payments made on its behalf to HSC and record such payment on Blue Cross' books as a special advance supplementary payment for each Provider which shall be separate and apart from any other advance or interim payments provided under this Agreement. Such special advance supplementary payments made by Blue Cross on behalf of the Provider pursuant to this Section 24 shall be included in the calculation of any "Retroactive Adjustment" as provided in subpart 2.4.5 of Exhibit A, Part I, for the fiscal year in which such payments were made.

24.6.3. Reimbursement by Blue Cross.

In calculating Blue Cross reimbursement, Provider shall include its proportionate share of the total cost of services to be performed by HSC in its administrative cost using an approved method of cost finding in accordance with subsection 2.3 of Exhibit A, Part I, and allocated in accordance with the approved method pursuant to subsection 2.2 of Exhibit A, Part I.

It is anticipated that the activities of HSC in the "Planning of Health Care Facilities" and the periodic review and evaluation of services will result in more effective use of hospital facilities and services, and reductions in the cost of rendering health care services in the total area covered. In many cases the reductions in costs realized will exceed the cost of HSC services to the Providers. These benefits will accrue to all institutions participating, and the various classes of patients and third party payers that they serve. Therefore, the Provider's proportionate

share of the HSC cost shall be shared by self-pay patients, Medicare, Medicaid, Blue Cross and/or any other third party payer. However, the one small segment of patients for which reimbursement of this cost will not be received, are those determined to be free.

In recognition of the potential benefits to be derived from this program in the containment of health care costs which will inure to Blue Cross subscribers, as well as to the community at large, Blue Cross agrees to assist each Provider to recover a portion of this cost as follows:

Blue Cross shall make an unrestricted grant annually at time of final settlement, separate and apart from any other reimbursement required by this Agreement, in an amount equal to 50% of that portion of the Provider's HSC expense applicable to the free work for which no reimbursement would otherwise be received. The calculation of the amount of this grant shall be made in the following manner:

> Calculate the percentage that the free work charges are to the total charges for the fiscal year 1969-1970. Multiply the total Provider's proportion of the HSC expense by this percentage, 50% of the resulting proportion attributable to free work of the HSC expense will be reimbursed by Blue Cross in addition to that portion calculated to be payable by the R.C.C.A.C. apportionment of Blue Cross' liability for Covered Services rendered to Subscribers.

The amount of this unrestricted grant is not to be included in the calculation of any "Retroactive Adjustment" as provided in subpart 2.4.5 of Exhibit A, Part I, of this Agreement.

Section 25. Superseded Contract.

The provision of any contract between Blue Cross and the Provider which this Agreement supersedes to the

contrary notwithstanding, the payments to be made by Blue Cross under said superseded contract to the Provider for all admissions prior to the effective date of this Agreement shall be at the rate in effect under said superseded contract at the date of such admission. The Provider shall not be reimbursed or paid by Blue Cross for any incentive payments it would have earned or otherwise been entitled to under any of the Principles numbered 2-5 through 2-9 inclusive, which were added to Exhibit A of the superseded Provider-Blue Cross Contract (Uniform Cost Contract 1967) by the July 1, 1970 amendment, except as to those incentive payments which were earned prior to July 1, 1971.

Section 26. Term of Agreement.

26.1. Subject to the provisions contained herein, this Agreement shall remain in effect until July 1, 1973, although it may be terminated earlier by either Provider or Blue Cross upon ninety days prior written notice to the other party or as provided in subsection 18.4 and Section 23 hereof.

26.2. In the event this Agreement terminates as provided heretofore, any depreciation allowed as a result of a subsequent contract between Blue Cross and the Provider shall be calculated using the asset basis and method established in accordance with Part I of Exhibit A.

Section 27. Obligations after Termination.

In the event this Agreement terminates for any of the reasons set forth herein, the Provider, if paid in accordance with Section 2 of this Agreement, shall continue to furnish services and facilities in accordance with the terms hereof to all persons who were Subscribers at the

time of their admission to the Provider, and (a) who were admitted to the Provider or treated as outpatients during the ninety day period following the date of such termination; or (b) who were inpatients on the date of such termination; or (c) who were admitted to the Provider during the unexpired portion of their agreement year current at the termination, i.e., the date 90 days after the delivery of notice of termination under subsection 26.1 or the similar date under other sections.

Section 28. Public Disclosure.

Provider and Blue Cross mutually agree that the public at large has a significant and continuing interest in the development of an effective, cost-efficient medical service program which is responsive to consumer needs. To ensure that the public is advised of the plans, programs and undertakings of both the Provider and Blue Cross, each party agrees that during the term of this Agreement they shall individually make available information relating to costs, facilities, services available and other pertinent financial and statistical data with respect to their own operation, and continue appropriate measures to assure adequate consumer participation in their respective activities.

Section 29. Section Headings.

The section headings used herein have been inserted for convenience of reference only and shall not in any way modify or restrict any of the terms or provisions hereof.

IN WITNESS WHEREOF, the parties hereto, intending to be legally bound, have caused these presents

Exhibit 17

to be executed by their proper officers as of the date of execution set forth below.

Date of Execution

_____ _____
Name of Provider

Effective Date

July 1, 1971 By _____
Signature

_____
Title of Signing Officer

BLUE CROSS OF GREATER PHILADELPHIA

_____
President

Exhibit 17

EXHIBIT A

PRINCIPLES OF REIMBURSEMENT

For purposes of establishing the amounts to be paid Provider by Blue Cross pursuant to this Agreement, Provider shall have the option during the term of this Agreement of being reimbursed on the basis of either a "Reasonable Cost" or "Prospective Rate" as such are more fully described hereinafter. The Provider must advise Blue Cross in writing which method it has elected prior to the end of the second month of the prospective fiscal year (for the first year of this Agreement such election must be made within thirty days following the execution of this Agreement). This election once made by Provider may not be changed for such fiscal year. In the event Provider fails to make an election within the prescribed period or is unable to reach agreement with Blue Cross on a Prospective Rate, the reimbursement to be paid Provider shall be calculated on the basis of "Reasonable Cost" as provided for in Part I of this Exhibit A.

PART I. REASONABLE COST BASIS

It is the intention of the parties hereto that application of the Principles set forth in Sections 1 and 2 hereof shall be made utilizing all current and future applicable Medicare interpretations, instructions and manuals containing informational and procedural matter as regards the various determinations of cost under these Principles, except where the Principles would make such material inappropriate.

No amendment to the Medicare Law nor change in the sections of the Medicare Regulations which are captioned "Principle" as were promulgated on July 1, 1967 shall be applicable to this Agreement.

Exhibit 17

Section 1. PRINCIPLES TO BE USED IN DETERMINING SPECIFIC REIMBURSABLE COSTS.

1.1. Allowance for Depreciation Based on Asset Costs.

Principle

An appropriate allowance for depreciation on buildings and equipment is an allowable cost. The depreciation to be allowed under this Agreement must be:

(a) Identifiable and recorded in the Provider's accounting records from the date of acquisition or appraisal if not recorded upon acquisition; and

(b) Based on the historical cost of the asset (including assets financed with Hill-Burton or other federal or public funds) or fair market value at the time of donation in the case of donated assets; and

(c) Prorated over the remaining estimated useful life of the asset as in use as of July 1, 1971, using the straight-line method and based on the remaining undepreciated value, if any, of the asset as of July 1, 1971 with respect to depreciation taken for Blue Cross purposes under previous contracts between the Provider and Blue Cross.

1.1.1. Definitions.

(a) *Historical cost* is the cost incurred by the present owner in acquiring the asset.

(b) *Fair market value* is the price which the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition. Usually the fair market price will be the price at which bona fide sales have been consummated for assets of like type, quality and quantity in a particular market at the time of acquisition.

Exhibit 17

(c) Under the *straight-line method of depreciation* the cost or other basis (e.g. fair market value in the case of donated assets) of the asset, less its estimated salvage value, if any, is first determined. This sum is then distributed equally over the estimated useful life of the asset.

1.1.2. Recording of Depreciation.

Appropriate recording of depreciation encompasses the identification of the depreciable assets in use, the assets' historical costs, estimated useful lives, and the assets' accumulated depreciation used for Blue Cross purposes. The "Chart of Accounts" published by the American Hospital Association shall be used as a guide in determining the estimated useful lives of assets.

1.1.3. Funding of Depreciation.

Although funding of depreciation is not required it is strongly recommended that Providers use this mechanism as a means of conserving funds for replacement of depreciable assets and coordinate their planning of capital expenditures with areawide planning activities of community and state agencies. As an incentive for funding, investment income on funded depreciation will not be treated as a reduction of allowable interest expense.

1.1.4. Gains and Losses on the Disposal of Depreciable Assets.

Gains and losses realized from the disposal of depreciable asets are to be included when computing allowable costs. If the gains or losses on the disposal of depreciable assets in a given fiscal year are greater than 10% of the total allowable depreciation for that period, the amount of gain or loss in excess of 10% must be carried forward

over the next five succeeding years. Proper books of account identifying the gain or loss carry-forward for each individual year must be separately maintained by Provider and any such carry-forward shall be considered first in determining the aforesaid 10% limitation for any year.

The amount of such gains and losses which are includable in allowable costs shall be calculated as follows:

(a) When an asset which was acquired by Provider before the date it entered into a "cost-type contract" with Blue Cross (hereinafter called the "Entry Date") is disposed of, a correction of prior years' depreciation based on actual life must be made before determining any gain or loss. The depreciation accumulated before the Entry Date must be corrected in the same manner as when making a new estimate of the asset's useful life. The gain or loss is the difference between the amount received for the asset and the corrected undepreciated cost at time of sale.

(b) Gain or loss on the disposal of assets acquired after the Entry Date is the difference between the sale price of the asset and the asset's unrecovered cost.

1.1.5. Establishment of Cost Basis on Purchase of Facility as Ongoing Operation.

In establishing the cost basis for a facility purchased as an ongoing operation after July 1, 1971, the price paid by the purchaser shall be the cost basis where the purchaser can demonstrate that the sale was a bona fide sale and the price paid did not exceed the fair market value of the facility at the time of sale. The cost basis for depreciation purposes pursuant to this Agreement shall not exceed the undepreciated value calculated for Blue Cross purposes of those assets at the time of sale. If a transaction is demonstrated to be other than a bona

fide sale, the purchaser's depreciable basis shall be the lesser of the seller's cost basis or the undepreciated value calculated for Blue Cross purposes of such assets at the time of sale.

1.2. Interest Expense.

Principle

Necessary and proper interest on both current and capital indebtedness is an allowable cost.

1.2.1. Definitions.

(a) *Interest* is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term which is usually for such purposes as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes such as acquisition of facilities and equipment, and capital improvements. Generally, loans for capital purposes are long-term loans.

(b) *Necessary* requires that the interest:

(i) Be incurred on a loan made to satisfy a financial need of the Provider. Loans which result in excess funds or investments shall not be considered necessary.

(ii) Be incurred on a loan for a purpose reasonably related to patient care.

(iii) Be reduced by investment income except where such income is from gifts and grants, whether restricted or unrestricted, and which are held separate and not commingled with other funds. Income from funded depreciation or the Provider's qualified pension fund shall not be used to reduce interest expense.

(c) *Proper* requires that interest:

(i) Be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made; or

(ii) Be paid to a lender not related through control or ownership, or personal relationship to the borrowing organization. However, interest is allowable if paid on loans from the Provider's donor-restricted funds, the funded depreciation account or the Provider's qualified pension fund.

1.2.2. Borrower-Lender Relationship.

(a) To be allowable, interest expense must be incurred on indebtedness established with lenders or lending organizations not related through control, ownership or personal relationship to the borrower. Presence of any of these factors could affect the "bargaining" process that usually accompanies the making of a loan and could thus be suggestive of an agreement on higher rates, interest or unnecessary loans. Loans should be made under terms and conditions that a prudent borrower would make in arms-length transactions with lending institutions. The intent of this provision is to assure that loans are legitimate and needed, and that the interest rate is reasonable. Thus, interest paid by the Provider to related organizations of the Provider is not allowable.

(b) Exceptions to the general rule regarding interest on loans from controlled sources of funds are made in the following circumstances. Interest on loans to the Provider by related organizations made prior to July 1, 1966 is an allowable cost, provided, the terms and conditions of payment of such loans have been maintained in effect without modification subsequent to July 1, 1966. Where

the general fund of a Provider "borrows" from a donor-restricted fund and pays interest to the restricted fund, the interest expense is an allowable cost. The same treatment shall be accorded interest paid by the general fund on money "borrowed" from the Provider's qualified pension fund, funded depreciation account or funds borrowed from the religious order responsible for the operation of the Provider.

(c) Where funded depreciation is used for purposes other than improvement, replacement or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in the Provider's qualified pension fund where such deposits are used for other than the purpose for which the fund was established.

(d) Allowable interest expense on the current indebtedness of the Provider will be adjusted to reflect the extent to which working capital needs attributable to Covered Services for Subscribers have been met by Blue Cross payments designed to provide reimbursement for services currently furnished to Subscribers.

1.3. Bad Debts, Charity, and Courtesy Allowances.

Principle

Bad debts, charity and courtesy allowances are deductions from revenue and are not to be included in allowable cost; however, bad debts attributable to deductibles and coinsurance amounts are reimbursable hereunder except with respect to those incurred by Subscribers who are covered by a Form 11 Subscription Agreement which may, subsequent to the effective date of this Agreement be made available by Blue Cross.

Exhibit 17

1.3.1. Definitions.

(a) *Bad debts* are amounts considered to be uncollectible from accounts and notes receivable which were created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from the rendering of services and are collectible in money in the relatively near future.

(b) *Charity allowances* are reductions in charges made by the Provider of services because of the indigence or medical indigence of the patient.

(c) *Courtesy allowances* are reductions in charges in the form of an allowance to physicians, clergy, members of religious orders and others as approved by the governing body of the Provider, for services received from the Provider. Employee fringe benefits, such as hospitalization and personal health programs, are not considered to be courtesy allowances.

(d) The *Form 11 Subscription Agreement* shall be a subscription agreement with a substantially greater coinsurance amount and/or deductible to be offered subsequent to the effective date of this Agreement which Blue Cross develops for Subscribers with the objective of having lower charges for such Subscription Agreement than those now offered, and that election of the new Subscription Agreement shall be on an optional basis.

1.3.2. Normal Accounting Treatment Reduction in Revenue.

Bad debts, charity and courtesy allowances represent reductions in revenue. The failure to collect charges for services rendered does not add to the cost of providing services. Such costs have already been incurred in the production of the services.

Exhibit 17

1.3.3. Requirements of this Agreement.

Under this Agreement the costs of Covered Services furnished Subscribers are not to be borne by individuals not covered by Blue Cross, and conversely, costs of services provided for other than Subscribers are not to be borne by Blue Cross. Uncollected revenue related to services rendered to Subscribers generally means the Provider has not recovered the cost of services covered by that revenue. The failure of Subscribers to pay the deductible and coinsurance amounts can result in the related costs of Covered Services being borne by other than Subscribers. The costs attributable to deductibles and coinsurance amounts, except as to debts incurred by Subscribers receiving Covered Services under a Form 11 Subscription Agreement, which remain unpaid, are to be added to the Blue Cross share of allowable costs. Bad debts arising from other sources are not allowable costs.

1.3.4. Criteria for Allowable Bad Debts.

A bad debt must meet the following criteria to be allowable:

(a) The debt must be related to Covered Services and derived from deductible and coinsurance amounts;

(b) The Provider must be able to establish that reasonable collection efforts were made;

(c) The debt was actually uncollectible when claimed as worthless; and

(d) Sound business judgment established that there was no likelihood of recovery at any time in the future.

1.3.5. Charging of Bad Debts and Bad Debt Recoveries.

The amounts uncollectible from specific Subscribers are to be charged off as bad debts in the accounting period in which the accounts are deemed to be worthless. In

some cases an amount previously written off as a bad debt and allocated to Blue Cross may be recovered in a subsequent accounting period, in such cases the income therefrom must be used to reduce the cost of Subscriber Covered Services for the period in which the collection is made.

1.3.6. Charity Allowances.

Charity allowances have no relationship to Subscribers and are not allowable costs. The cost to the Provider of employee fringe-benefit programs is an allowable element of reimbursement.

1.4. Cost of Educational Activities.

Principle

An appropriate part of the net cost of approved educational activities is an allowable cost.

1.4.1. Definitions.

(a) *Approved educational activities* means formally organized or planned programs of study usually engaged in by the Provider in order to enhance the quality of patient care at an institution. These activities must be licensed where required by state law. Where licensing is not required, the institution must receive approval from the recognized national professional organizations for the particular activity.

(b) The *net cost* means the cost of approved educational activities (including stipends of trainees, compensation of teachers and other costs) less any reimbursements from grants, tuition, fellowships and other specific donations.

(c) *Appropriate part* means the net cost of the approved activity apportioned in accordance with the method set forth in this Exhibit A, Part I.

1.4.2. Educational Activities.

Many Providers engage in educational activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties. These programs contribute to the quality of patient care within an institution and are necessary to meet the community's needs for medical and paramedical personnel. It is recognized that the costs of such educational activities should be borne by the community, however, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, Blue Cross will participate appropriately in the support of these activities. Although the intent of Blue Cross is to share in the support of educational activities customarily or traditionally carried on by Providers in conjunction with their operations, it is not intended that Blue Cross should participate in increased costs resulting from distribution, transfer or redistribution of costs from educational institutions or units.

1.4.3. "Orientation" and "On-the-Job Training."

The cost of orientation and on-the-job training are not within the scope of this subsection but are recognized as normal operating costs in accordance with the subsections relating thereto.

1.4.4. Approved Programs.

In addition to approved medical, osteopathic, and dental internships and residency programs, recognized professional and paramedical educational and training programs now being conducted by Provider institutions, and their approving bodies, include the following:

Exhibit 17

Program	*Approving Bodies*
(a) Cytotechnology	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Medical Technology, American Society of Clinical Pathologists.
(b) Dietetic interships ..	The American Dietetic Association.
(c) Hospital administration residencies ..	Members of the Association of University Programs in Hospital Administration.
(d) Inhalation therapy..	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Inhalation Therapy.
(e) Medical records	Council on Medical Education of the American Medical Association in collaboration with the Committee on Education and Registration of the American Association of Medical Record Librarians.
(f) Medical technology .	Council on Medical Education of the American Medical Association in collaboration with the Board of Schools of Medical Technology, American Society of Clinical Pathologists.
(g) Nurse anesthetists ..	The American Association of Nurse Anesthetists.

Exhibit 17

Program	*Approving Bodies*
(h) Professional nursing	Approved by the respective state approving authorities. Reported for the United States by the National League for Nursing.
(i) Practical nursing ..	Approved by the respective state approving authorities. Reported for the United States by the National League for Nursing.
(j) Occupational therapy	Council on Medical Education of the American Medical Association in collaboration with the Council on Education of the American Occupational Therapy Association.
(k) Pharmacy residencies	American Society of Hospital Pharmacists.
(l) Physical therapy ...	Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association.
(m) X-ray technology ...	Council on Medical Education of the American Medical Association in collaboration with the American College of Radiology.

1.4.5. Other Educational Programs.

There may also be other educational programs not included in the foregoing in which the Provider is engaged. Appropriate consideration will be given by Blue Cross to the costs incurred for those activities that come within the purview of this subsection when determining allowable costs for apportionment under this Agreement.

1.4.6. Joint Study.

A joint study shall be undertaken at the onset of this Agreement by independent consultants acceptable to those Providers which are signatories hereto, or their nominee, and Blue Cross in order to establish standards which can be used to determine the number of interns and residents as well as the salary, fringe benefits, and other costs including those of the Director of Medical Education and other physicians participating in their teaching programs which are necessary for the maintenance of high quality care in the various categories of hospitals. The standards so determined shall be implemented as promptly as possible by the Provider (within the contractual limitations already established with interns, residents and other personnel) and any such personnel then in excess of such established standards shall be considered to be for purely educational purposes unrelated to patient care and the cost therefor shall not be reimbursable under this Agreement.

1.4.7. Limitation.

If Provider had a net per diem cost attributable to interns and residents (such cost shall include the salaries and special perquisites not provided other employees, the salary and cost of the Director of Medical Education, and the costs associated with other physicians

engaged either full or part time in education of residents and interns, but excluding malpractice insurance) in excess of three dollars and fifty cents ($3.50) per patient day in 1970-1971, the reimbursement to be provided hereunder shall be limited during the fiscal year 1971-1972 to one hundred twelve percent (112%) of costs attributable to interns and residents for the fiscal year 1970-1971, and during the fiscal year 1972-1973 to one hundred and seven percent (107%) of the fiscal 1971-1972 allowable cost. The foregoing limitation is separate and apart from any other limitation or reimbursement contained herein.

1.5. Research Costs.

Principle

Identifiable costs incurred directly or indirectly for research purposes which exceed normal costs of usual patient care and are not otherwise reimbursed, shall be excluded from allowable cost.

Application

(a) There are numerous sources of financing for health-related research activities. Funds for this purpose are provided under many federal programs and by other tax-supported agencies. Also, many foundations, voluntary health agencies, and other private organizations, as well as individuals, sponsor or contribute to the support of medical and related research. Funds available from such sources are generally ample to meet basic medical and hospital research needs.

(b) To ensure that all identifiable costs associated either directly or indirectly with research are not included in computing reimbursable cost, Provider shall maintain detailed books of account and other records as are necessary to identify research costs.

(c) Normal and usual costs of patient care which are not reimbursed from other sources shall be included as an allowable cost when incurred directly or indirectly for research purposes.

1.6. Grants, Gifts and Income From Endowments.

Principle

Unrestricted grants, gifts and income from endowments should not be deducted from operating costs in computing reimbursable cost. Grants, gifts or endowment income designated by a donor for paying specific operating costs shall be deducted from the particular operating cost or group of costs.

1.6.1. Definitions.

(a) *Unrestricted grants, gifts and income from endowments* are funds, cash or otherwise, given to the Provider without restriction by the donor as to their use.

(b) *Designated or restricted grants, gifts and income from endowments* are funds, cash or otherwise which must be used only for specific purposes designated by the donor, but does not refer to unrestricted grants, gifts or income from endowments which have been restricted for a specific purpose by the Provider.

1.6.2. Application.

(a) Unrestricted funds, cash or otherwise, are generally the property of the Provider to be used in any manner its managment deems appropriate and should not be deducted from operating costs. It would be inequitable to require the Provider to use the unrestricted funds to reduce the payments for care. The use of these funds is generally a means of recovering costs which are not otherwise recoverable.

(b) Donor-restricted funds which are designated for paying certain operating expenses of the Provider should apply and serve to reduce these costs or group of costs and benefit all patients who use services covered by the donation. If such costs are not reduced, the Provider would secure reimbursement for the same expense twice; it would be reimbursed through the donor-restr ted contributions as well as from patient and third-party payers including Blue Cross.

1.7. Value of Services of Nonpaid Workers.

Principle

The value of services in positions customarily held by full-time employees performed on a regular, scheduled basis by individuals as nonpaid members of organizations under arrangements between such organizations and the Provider for the performance of such services without direct remuneration from the Provider to such individuals is allowable as an operating expense for the determination of allowable cost subject to the limitation contained in this subsection. The amounts allowed are not to exceed those paid others for similar work. Such amounts must be identifiable in the records of the institutions as a legal obligation for operating expenses and paid no later than the end of the Provider's fiscal year following the fiscal year during which the services were rendered.

1.7.1. Limitations; Services of Nonpaid Workers.

To be reimbursable, the services of nonpaid workers must be performed on a regular, scheduled basis in positions customarily held by full-time employees and be necessary to enable the Provider to carry out the functions of normal patient care and operation of the institution. The value of services of a type for which Pro-

viders generally do not remunerate individuals performing such services is not allowable as a reimbursable cost under this Agreement. For example, donated services of individuals in distributing books and magazines to patients, or in serving in a Provider canteen, cafeteria or gift shop, would not be reimbursable.

1.7.2. Application.

The following illustrates how the Provider would determine an amount to be allowed under this subsection. The prevailing salary for a lay nurse working in hospital A is $5,000 for the year. The lay nurse receives no maintenance or special perquisites. A sister working as a nurse engaged in the same activities in the same hospital receives maintenance and special perquisites which cost the hospital $2,000 and are included in the hospital's allowable operating costs. The hospital would then include in its records an additional $3,000 to bring the value of the services rendered to $5,000. The amount of $3,000 would be allowable where the Provider assumes obligation for the expense under a written agreement with the sisterhood or other religious order covering payment by the Provider for the services.

1.8. Purchase Discounts, Allowances and Refunds of Expenses.

Principle

Discounts and allowances received on the purchase of goods or services are reductions of the cost to which they relate. Similarly, refunds of previous expense payments are reductions of the related expense.

1.8.1. Definitions.

(a) *Discounts* are generally reductions granted for the settlement of debts.

(b) *Allowances* are deductions granted for damage, delay, shortage, imperfection or other causes, excluding discounts and returns.

(c) *Refunds* are amounts paid back or a credit allowed on account of an overcollection.

1.8.2. Normal accounting treatment: reduction of costs.

All discounts, allowances and refunds of expenses are reductions in the cost of goods or services purchased and are not income. When they are received in the same accounting period in which the purchases were made or expenses were incurred, they will reduce the purchases or expenses of that period. However, when they are received in a later accounting period they will reduce the comparable purchases or expenses in the period in which they are received.

1.8.3. Application.

(a) Purchase discounts have been classified as cash, trade or quantity discounts. Cash discounts are reductions granted for the settlement of debts before they are due. Trade discounts are reductions from list prices granted to a class of customers before consideration of credit terms. Quantity discounts are reductions from list prices granted because of the size of individual or aggregate purchase transactions. Whatever the classification of purchase discounts, like treatment in reducing allowable costs is required. In the past, purchase discounts were considered as financial management income, however, modern accounting theory holds that income is not derived from a purchase but rather from a sale or an exchange and that purchase discounts are therefore reductions in the cost of whatever was purchased. The true cost of the goods or services is the net amount actually paid for them.

Treating purchase discounts as income would result in an overstatement of costs to the extent of the discount.

(b) As with discounts, allowances and rebates received from purchases of goods or services, refunds or previous expense payments are clearly reductions in cost and must be reflected in the determination of allowable costs. This treatment is equitable and in accord with that generally followed by governmental programs and other third-party organizations paying on the basis of cost.

1.9. Cost of Related Organizations.

Principle

Costs applicable to services, facilities and supplies furnished to the Provider by organizations related to the Provider by common ownership or control are includable in the allowable cost of the Provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities or supplies that could be purchased elsewhere.

1.9.1. Definitions.

(a) *Related to the Provider* means that the Provider to a significant extent is associated or affiliated with, has control of, or is controlled by the organization furnishing the services, facilities or supplies, provided, however, cooperative organizations sponsored by three or more Providers shall not be deemed "related to the Provider."

(b) *Common ownership* exists when an individual or individuals possess significant ownership or equity in the Provider and the institution or organization serving the Provider.

(c) *Control* exists where an individual or an organization has the power, directly or indirectly, significantly

to influence or direct the actions or policies of an organization or institution.

1.9.2. Application.

(a) Individuals and organizations associate with others for various reasons and by various means. Some deem it appropriate to do so to assure a steady flow of supplies or services, to reduce competition, to gain a tax advantage, to extend influence and for other reasons. These goals may be accomplished by means of ownership or control, by financial assistance, by management assistance and other ways.

(b) Where the Provider obtains items of services, facilities or supplies from an organization even though it is a separate legal entity, and the organization is owned or controlled by the owner(s) of the Provider, in effect the items are obtained from itself. An example would be a corporation building a hospital or a nursing home and then leasing it to another corporation controlled by the owner. Therefore, reimbursable cost should include the costs for these items at the cost to the supplying organization. However, if the price in the open market for comparable services, facilities or supplies is lower than the cost to the supplier, the allowable cost to the Provider shall not exceed the market price.

1.9.3. Exception.

An exception is provided to this general principle if the Provider demonstrates by convincing evidence to the satisfaction of Blue Cross that (i) the supplying organization is a bona fide separate organization; (ii) a substantial part of its business activity of the type carried on with the Provider is transacted with others than the Provider and organizations related to the supplier by

common ownership or control and there is an open, competitive market for the type of services, facilities or supplies furnished by the organization; (iii) the services, facilities or supplies are those which commonly are obtained by institutions such as the Provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions; and (iv) the charge to the Provider is in line with the charge for such services, facilities or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities or supplies. In such cases, the charge by the supplier to the Provider for such services, facilities or supplies shall be an allowable cost.

Section 2. GENERAL PRINCIPLES OF REIMBURSEMENT.

2.1. Cost Related to Patient Care.

Principle

All payments to Providers of services must be based on the "reasonable cost" of services covered and related to the care of Subscribers except to Providers which charge on an overall hospital basis less than cost for Covered Services or which elect to be reimbursed for outpatient Covered Services under any of the options provided in subsection 2.4 of this Exhibit A, Part I. Reasonable cost includes all necessary and proper cost incurred in rendering the services, subject to principles relating to specific items of revenue and cost. Any Provider cost for Covered Services which would have been attributable to Part B of Medicare if the case had been covered under Medicare, shall be included.

2.1.1. Definitions.

(a) The *reasonable cost* of services is defined as that cost which is allowable under this Agreement. The cost of any services must be determined in accordance with regulations establishing the method to be used and the items to be included. The regulations in this subsection take into account both direct and indirect costs of the Provider. The objective of this subsection is to ensure that reasonable costs associated with Subscriber Covered Services will not be borne by individuals not so covered and the costs with respect to individuals not so covered will not be borne by Blue Cross. These regulations also provide for the making of suitable retroactive adjustments after the Provider has submitted fiscal and statistical reports. The retroactive adjustment will represent the difference between the amount received by the Provider during the year for Covered Services from both Blue Cross and Subscribers and the amount determined in accordance with an accepted method of cost apportionment to be the actual allowable cost of Covered Services rendered to Subscribers during such year.

(b) *Necessary and proper costs* are costs which are appropriate and allowable in developing and maintaining the operation of patient care facilities and activities. They are usually costs which are common and accepted occurrences in the field of the Provider's activity.

(c) *Allowable costs* are those inpatient per diem costs as determined hereunder subject to the limitations set forth in subsection 18.4 of the Agreement and subsection 1.4 of this Exhibit A, Part I.

The above limitations are subject to appropriate revision if major unanticipated changes occur which are beyond the control of either the Provider or Blue Cross as provided in subsection 18.4.3 of the Agreement.

2.1.2. Application.

(a) It is the intent of this Agreement that payments to the Provider should be fair and equitable to both the Provider and Blue Cross.

(b) The costs of Providers of services vary from one Provider to another and the variations generally reflect differences in scope of services and intensity of care. The provision for payment of reasonable cost of Covered Services is intended to meet the actual costs, however widely they may vary from one institution to another.

(c) The determination of reasonable cost of Covered Services must be based on costs related to the care of Subscribers. Reasonable cost includes all necessary and proper expense incurred in rendering Covered Services, such as administrative costs, maintenance costs, and premium payments for employee health and pension plans. It includes both direct and indirect costs and normal standby costs. However, where the Provider's operating costs include amounts not related to patient care, or specifically not reimbursable under the Subscription Agreement, such amounts will not be allowable. The reasonable cost basis of reimbursement contemplates that the Provider will be reimbursed the actual costs of providing quality care however widely the actual costs may vary from Provider to Provider and from time to time for the same Provider.

(d) Notwithstanding subparagraphs (b) and (c) above, in determining the reasonableness of (i) budgeted expenses, (ii) gross inpatient per diem rates of interim payments by Blue Cross to Provider under subsection 18.1 of the Agreement, and (iii) costs exceeding the budgeted costs for reasons not covered by subsections 18.4.2, 18.4.3 or 18.4.4 of the Agreement, but for no other purpose, Blue Cross may reduce the proposed rate of interim payments or the final payment pursuant to subsection 2.4.5(b) of this Exhibit A, Part I, as appropriate, if Provider's costs, adjusted to remove any adverse variable produced by the rate of occupancy, are substantially higher than the costs of other hospitals in the same area which are similar in size, scope of services, utilization and other relevant factors. "Utilization" for this purpose refers not to Provider's occupancy rate but rather to the manner in which Provider is used as determined by the characteristics of the patients treated (i.e. its patient mix —age of patients, type of illness, etc.). If Blue Cross reduces Provider's payments pursuant to this subpart (d), Blue Cross shall have the burden of proving that the other hospitals, with the costs of which it compared the costs of Provider, have the similarity required hereby to a greater extent than any other area hospitals. All costs payable pursuant to Section 10 of the Agreement shall be considered in all comparisons made.

2.2. Determination of Cost of Covered Services to Blue Cross Subscribers.

Principle

Total allowable costs of a Provider shall be apportioned between Blue Cross Subscribers and other patients so that the share borne by Blue Cross is based upon actual Covered Services received by Subscribers. To accomplish this apportionment, the Provider shall use the departmental method for cost determination unless an alternative method is approved by the Provider and Blue Cross.

2.2.1. Definitions.

(a) Under the *departmental method* the ratio of Subscriber charges for Covered Services to total patient

charges for the services of each department is applied to the cost of that department.

(b) *Apportionment* means an allocation or distribution of allowable cost between Subscribers and other patients.

(c) *Routine services* means the regular room, dietary, and nursing services, minor medical and surgical supplies and the use of equipment and facilities for which a separate charge is not customarily made.

(d) *Ancillary services* or special services are the services for which charges are customarily made in addition to routine services.

(e) *Charges* refers to the regular rates for various services which are charged to both Subscribers and other patients who receive the services. Implicit in the use of charges as the basis for apportionment is the objective that charges for services be related to the cost of the services and such charges shall be the same for all classes of patients.

(f) *Cost* refers to reasonable cost as described in subsection 2.1 hereof.

(g) The *ratio of Suscriber charges for Covered Services to total charges on a departmental basis,* as applied to inpatients, means the ratio of inpatient charges to Subscribers covered for services of a revenue-producing department or center to the inpatient charges of all patients for that center during an accounting period. After each revenue-producing center's ratio is determined the cost of Covered Services rendered to Subscribers is computed by applying the individual ratio for the center to the cost of the related center for the period.

2.2.2. Application.

(a) This Agreement provides that the costs of Covered Services with respect to individuals covered by Blue Cross will not be borne by individuals not so covered, and conversely, that costs with respect to individuals who are not covered by Blue Cross will not be borne by Blue Cross.

(b) The cost of Covered Services to Subscribers is to be determined by the Provider using the Departmental Method; the objective of which is to approximate as closely as practicable the actual cost of services rendered.

(c) The method of apportionment for use in determining the cost of Covered Services rendered to Subscribers has as its goal the allocation of total allowable costs between Subscribers and other patients in as equitable a manner as possible. If it is found that Subscribers receive more than the average amount of services, the Provider would receive reimbursement greater than average costs for all patients. Conversely, if Subscribers receive less than the average amount of services, the Provider would be reimbursed accordingly for the services rendered.

2.3. Adequate Cost Data and Cost Finding.

Principle

Providers receiving payment on the basis of reasonable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. However, where governmental institutions operate on a cash basis of accounting, cost data based on such basis of account-

ing wil be acceptable, subject to appropriate treatment of capital expenditures.

2.3.1. Definitions.

(a) *Cost finding* is the process of recasting the data derived from the accounts ordinarily kept by a Provider to ascertain costs of the various types of services rendered. It is the determination of these costs by the allocation of direct costs and proration of indirect costs.

(b) Under the *accrual basis of accounting* revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

2.3.2. Adequacy of Cost Information.

Adequate cost information must be obtained from the Provider's records to support payments made for services rendered to Subscribers. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended. Adequate data capable of being audited is consistent with good business concepts, and effective and efficient management of any organization, whether it is operated for profit or on a nonprofit basis. It is a reasonable expectation on the part of any agency paying for services on a cost-reimbursement basis. In order to provide the required cost data and not impair comparability, financial and statistical records should be maintained in a manner consistent from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures when there is reason to effect such change.

2.3.3. Uniform Accounting Procedures.

Implicit in providing adequate cost information is uniformity in reporting among all hospitals under this Agreement and therefore the Provider shall comply with the instructions to be issued from time to time to accomplish this as agreed to among Blue Cross and the hospitals under this Agreement.

2.3.4. Inadequate Data.

If the Provider is unable to provide adequate data, Blue Cross and the Provider will make an appropriate estimate for use in support of payments to be made for Covered Services rendered to Subscribers.

2.3.5. Cost Finding Methods.

After the close of the accounting period, one of the following methods of cost finding is to be used to determine the actual costs of services rendered during that period.

(a) *Step-down method.* This method recognizes that services rendered by certain nonrevenue-producing departments or centers are utilized by certain other nonrevenue producing centers as well as by the revenue-producing centers. All costs of nonrevenue-producing centers are allocated to all centers which they serve regardless of whether or not these centers produce revenue. The cost of the nonrevenue-producing center serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. Following the apportionment of the cost of the nonrevenue-producing center, that center will be considered "closed" and no further costs are apportioned to that center. This applies even though it may have received

some service from a center whose cost is apportioned later. Generally when two centers render service to an equal number of centers while receiving benefits from an equal number, that center which has the greatest amount of expense should be allocated first.

(b) *Other methods*—(i) *Double-apportionment method.* The double-apportionment method may be used by the Provider upon approval of Blue Cross. This method also recognizes that the nonrevenue-producing departments or centers render services to other nonrevenue-producing centers as well as the revenue-producing centers. A preliminary allocation of the costs of the nonrevenue-producing centers is made. These centers or departments are not "closed" after this preliminary allocation. Instead, they remain "open" accumulating a portion of the costs of all other centers from which services are received. Thus, after the first or preliminary allocation, some costs will remain in each center representing services received from other centers. The first or preliminary allocation is followed by a second or final apportionment of expenses involving the allocation of all costs remaining in the nonrevenue-producing centers directly to the revenue-producing centers. However, having elected to use the double-apportionment method, the Provider may not thereafter use the step-down method without approval of Blue Cross.

(ii) *More sophisticated methods.* A more sophisticated method designed to allocate costs more accurately may be used by the Provider upon approval of Blue Cross. Request for the approval of such methods must be made on a prospective basis and submitted before the end of the first month of the prospective reporting period. Likewise, once having elected to use a more sophisticated method, the Provider may not thereafter use either the

double-apportionment or step-down methods without similar request and approval.

2.3.6. Accounting Basis.

The cost data submitted hereunder must be based on the accrual basis of accounting which is recognized as the most accurate basis for determining costs. However, governmental institutions that operate on a cash basis of accounting may submit cost data on the cash basis subject to appropriate treatment of capital expenditures.

2.4. Payments to Providers.

Principle

The Provider will be paid the reasonable cost of Covered Services furnished to Subscribers except for the options to receive payments for Covered Services provided to outpatients at a percentage of charges. Interim payments approximating the actual costs of the Provider will be made on the most expeditious basis administratively feasible but not less often than semi-monthly. A retroactive adjustment based on actual costs will be made at the end of the reporting period. At the request of the Provider, payment will be made on the basis designed to reimburse currently for Covered Services rendered to Subscribers.

2.4.1. Amount and Frequency of Payment.

The Provider will be paid the reasonable cost of Covered Services furnished to Subscribers. Since actual costs of Covered Services cannot be determined until the end of the accounting period, the Provider must be paid on an estimated cost basis during the year. Interim payments shall be made no less often then semi-monthly, and Blue Cross will make payments on the most expeditious

basis administratively feasible. The estimated cost basis for determining interim payments during the year shall be based on one hundred percent of the Provider's budget submitted in accordance with Section 18 of this Agreement, as approved by Blue Cross, so that the retroactive adjustment based on actual costs will be as small as possible.

2.4.2. Optional Methods of Reimbursement for Covered Services Provided to Outpatients.

In lieu of receiving payments on the basis of reasonable costs as herein provided for Covered Services furnished to outpatients, the Provider may elect to receive payments for such services on the basis of either eighty or ninety percent of charges less d[illegible]e, or co-payment amounts, if any. If the Provider elects the ninety percent method, the payments to be made by Blue Cross will be subject to the limitation that increases in Provider's outpatient charges shall be limited to an increase not to exceed the percentage increase in total allowable cost applicable to the same fiscal year. The Provider shall make the foregoing election by submitting to Blue Cross in writing a document indicating which option it desires within fifteen days subsequent to the date Provider executes this Agreement for the fiscal year 1971-1972, and for the fiscal year 1972-1973, within sixty days after the beginning of such year. In the event the Provider shall make such election for either or both fiscal years, the retrocative adjustments hereinafter set forth in the subsection 2.4 hereof shall not apply for the fiscal year or years for which such election is made.

2.4.3. Interim Payments.

The gross interim inpatient per diem rates of payment will be determined based on the Provider's approved budget as submitted in accordance with subsection 18.2 of the Agreement. This interim rate of payment may be adjusted by Blue Cross during an accounting period if the Provider submits appropriate evidence that its actual costs are or will be significantly higher than the computed rate within the limitations and exceptions set forth in subsection 18.4 of the Agreement. Likewise, Blue Cross may adjust the interim rate of payment if it has evidence that actual costs may fall significantly below the computed rate.

2.4.4. Determination of Interim Payments to Providers.

(a) Inpatient interim rates of payment will be a gross per diem cost including the total reasonable cost of all services, both covered and non-covered, to Subscribers. This gross per diem cost will then be adjusted by multiplying it by the percentage that charges for Covered Services (including deductibles and coinsurance amounts) are to total charges for all services on a per case basis. Deductible and coinsurance amounts, as well as the ward differential, if any, will then be deducted to determine the final interim payment for that individual Subscriber's case.

Example: On a six day stay under the Co-Pay Comprehensive Subscription Agreement with the following, arbitrarily chosen amounts, the remittance would be calculated as follows:

Gross Per Diem cost	$ 60.00
Total Charge to Subscriber	400.00
Charges for Blue Cross Covered Services (same as Blue Cross Allowance)	390.00
6 days × $60.00 Gross Per Diem Cost	360.00

Multiplied By:

$\frac{\$390.00 \text{ (Charges for Covered Services)}}{\$400.00 \text{ (Total Charges)}}$ 351.00

Less:

Co-Payment: 6 days at $5.00 per day .. 30.00

Ward Differential 0

Remittance to Provider $321.00

(b) Outpatient interim rates, except when Provider has elected an optional method of reimbursement, will be a percentage of charges based on outpatient cost and charge information of the Provider and calculated using the Provider's budget as submitted in accordance with subsection 18.2 of the Agreement to approximate cost as nearly as possible.

2.4.5. Retroactive Adjustment.

(a) The Provider shall be paid amounts determined to be due, but not less often than semi-monthly, with necessary adjustments due to previously made overpayments or underpayments. Interim payments are made on the basis of approved budgeted costs. Actual reasonable costs reimbursable to a Provider cannot be determined until the cost reports are filed and costs are verified. Therefore, a retroactive adjustment will be made at the end of the reporting period to bring the interim payments made to the Provider during the period into agreement with the reimbursable amount payable to the Provider for the Covered Services rendered to Subscribers during that period.

(b) In order to reimburse the Provider as quickly as possible, an initial retroactive adjustment will be made as soon as the cost report is received and the desk review completed. For this purpose, the cost will be accepted as

reported—unless there are obvious errors or inconsistencies—subject to later audit. The amount determined as a result of the desk review shall be payable in full within thirty days following such review to either the Provider or Blue Cross, as appropriate. When an audit is made and the final liability of Blue Cross is determined, a final adjustment will be made.

(c) To determine the retroactive adjustment, the amount of the Provider's total allowable reasonable cost apportioned to Blue Cross for the reporting year is computed. This is the total amount of cost reimbursement the Provider is due to receive from Blue Cross and Subscribers for Covered Services rendered during the reporting period. The total of the interim payments made by Blue Cross in the reporting year and the deductibles and coinsurance amounts receivable from Subscribers is next computed. The difference between the reimbursement due and the sum of payments made by Blue Cross and amounts payable by Subscribers is the amount of the retroactive adjustment.

2.4.6. Payments to Hospitals which Charge Less than Cost.

Payments to hospitals which on an overall hospital basis charge less than cost for inpatient covered services will be based on charges and related to the percentage of total Blue Cross inpatient days in such institutions in the following manner:

If less than ten percent of the total Blue Cross inpatient days occur in hospitals which charge less than cost, payment to such hospitals shall be one hundred percent of charges for Covered Services. For each five percent increase in the percentage of total Blue Cross inpatient days which occur in hospitals which charge less than cost, in excess of the first ten percent, the percent of

charges paid to such hospitals shall be decreased one percent. The payment to such hospitals, however, shall never be less than ninety-five percent of charges.

2.4.7. Provision for Current Financing.

In addition to the basic procedure for payment to the Provider following the submission of bills to Blue Cross, payment will be made upon request by the Provider on a basis designed to reimburse currently for Covered Services furnished to Subscribers. The amount of such payment will be computed by Blue Cross and periodically adjusted to represent the average level of Covered Services unreimbursed by the basic payment procedure.

2.4.8. Cost Reporting Period.

For cost reporting purposes, Blue Cross will require submission of reports of operations based upon the Provider's accounting year within one hundred and twenty days of the close of the Provider's fiscal year.

PART II. PROSPECTIVE RATE BASIS.

If the Provider elects to be reimbursed on a prospective rate basis, it shall submit to Blue Cross the material required for budgetary review as provided in subsection 18.1 of the Agreement. Using this material and other data which it may request, Blue Cross and the Provider shall establish a gross prospective per diem rate, which shall be based on the principles set forth in Part I of this Exhibit A.

1. Inpatient Services.

The provider shall be reimbursed for inpatient Covered Services provided to Subscribers based on a gross prospective per diem rate which shall be determined

to the mutual satisfaction of Provider and Blue Cross in accordance with the terms and limitations set forth in this Agreement. In the event Provider is reimbursed for inpatient Covered Services in accordance with this Part II, those principles set forth in Part I of this Exhibit A which apply to reimbursement for inpatient services shall not alter or modify such fixed prospective rate, but the computation of inpatient claims shall be made in the manner as provided in subsection 2.4.4 "Determination of Interim Payment to Providers" of Part I of this Exhibit A, and such payments shall be final payment. No retroactive adjustment to such payments shall be made on the basis of actual cost except as otherwise provided in subsection 18.5 of this Agreement.

2. Outpatient Services.

In determining the payments for outpatient services to be made to a Provider who has elected to be reimbursed on a prospective rate basis, the Provider shall elect at the time such prospective rate is established which of the options available under subsection 2.4 of Part I of this Exhibit A it desires. The foregoing election shall be binding upon the Provider for the fiscal year covered by such prospective rate, but may be changed when a new prospective rate is established for a subsequent fiscal year.

3. Other Requirements.

Providers electing to be reimbursed on the prospective rate basis shall be subject to all the provisions in this Agreement except where specifically stated otherwise in this Part II of this Exhibit A or elsewhere in this Agreement.

EXHIBIT B

OPERATING BUDGET

INSTRUCTIONS

Introduction

The budget forms were prepared by the Joint Blue Cross-Hospital Council Task Force on Budget Review.

The form and content includes the information necessary for conformity with the new Blue Cross "Hospital Agreement" under provision section 18 "Budgetary Review Procedure."

Section 18. Budgetary Review Procedures.

18.1. Submission of Budgets.

Provider shall submit its annual budget to Blue Cross at least forty-five days prior to the first day of Provider's fiscal year on the standard form which is attached hereto as Exhibit B, as such may be modified from time to time. The budget shall include a proposed gross inpatient per diem rate for interim payments by Blue Cross to Provider. The budget as submitted to Blue Cross shall have had the prior approval of Provider's Budgetary Committee or similar financial committee, the membership of which shall include at least one member of Provider's governing body. For Provider's first fiscal year under this Agreement, the foregoing requirement may be satisfied by submission of Provider's budget in its own format with comparative information in such reasonable detail as is necessary to distinguish inpatient and outpatient costs, determine the effects of any wage-price stabilization policies on anticipated costs in the budgeted year, and permit line comparisons with previous years' budgets and financial results of operations as soon as reasonably possible

after the execution of this Agreement, but in no event later than 30 days after the execution hereof. The budgets submitted in accordance with this subsection 18.1 shall include all adjustments made necessary by the application of federal price stabilization requirements.

18.2. Interim Payments.

Blue Cross shall review the data submitted by Provider to determine the reasonableness of the expenses included therein in accordance with the provisions contained in Exhibit A hereof utilizing the following procedures:

18.2.1. If Blue Cross shall determine that the estimates set forth in the budget submitted by the Provider are reasonable within the meaning of subsection 2.1 of Exhibit A, Part I hereof, Blue Cross shall so advise the Provider and use the gross inpatient interim per diem rate proposed by Provider for admissions during such budgeted fiscal year.

18.2.2. If Blue Cross determines that the cost estimates included in Provider's budget as submitted are unreasonable, or that the gross inpatient interim per diem rate proposed by Provider has not been properly computed, Blue Cross shall within forty-five days of its receipt of said budget so advise Provider and request a meeting with Provider's representatives to review the matter and determine whether appropriate modifications should be made in the budget or the gross inpatient interim per diem rate. If Blue Cross does not so advise Provider within the aforesaid forty-five day period, Blue Cross shall reimburse Provider based on the gross inpatient interim per diem rate proposed by Provider until such time as a meeting can be held to review the reasonableness of Provider's budget.

Exhibit 17

18.2.3. If Provider and Blue Cross are unable to reach agreement as to the reasonableness of the budgeted costs, Blue Cross shall determine the gross inpatient interim per diem rates for the budgeted year based upon its review and findings, considering any supplemental data submitted by Provider. In such event, Provider may exercise its right of appeal as set forth in Section 21 hereof, accepting the interim rate set by Blue Cross until a final decision is rendered by the Appeals Board or Court, as appropriate. However, it is expressly understood by the parties hereto that the foregoing right of appeal shall pertain only to gross inpatient interim per diem rates as determined above and does not extend to any rate fixed pursuant to subsection 18.5.

18.2.4. When the gross inpatient interim per diem rates have been based on unaudited data, such rates shall be subject to appropriate increase or decrease retroactively and prospectively if the net audit adjustments, excluding non-recurring items, amount in aggregate to more than one dollar ($1.00) per patient day subject to the limitations contained in subsection 18.4.

18.2.5. All gross inpatient interim per diem rates established pursuant to this Agreement shall be subject to review and adjustment in the event a major unforeseeable and unanticipated cost increase or decrease occurs during the fiscal year, in which case the Provider shall so advise Blue Cross promptly of such changes and forward to Blue Cross the appropriate supporting data.

Statistical definitions shall conform to the A.H.A. Uniform Hospital Definitions dated 1960.

Providers are required to enter their name, Blue Cross Code Number and the applicable dates on each page in the spaces provided, also enter applicable dates in the headings, "Actual, Projected and Budget."

Exhibit 17

Budget Forms

A. Summary of Costs
B. Calculation of Tentative Blue Cross Gross Payment Rate
C. Departmental Summary and Per Diem Calculation
D. Statistics
E. Salaries & Wages-Employees & Fees
F. Supplies & Expenses
G. Depreciation Expense
H. Analysis of Recovery of Expense Items
I. Personnel Policies
J. Supplemental Questionnaire
K. Comparative Report Educational Expenses

Filing Date

Budget forms should be prepared and submitted forty-five days (45) days prior to the beginning of the fiscal year.

Number of Copies Required

All forms should be completed and filed in *duplicate*. (Typing not required, but must be legible copy.)

Actual Expenses

Should represent actual expenses for the first complete preceding fiscal year.

Projected Expenses

Provider should indicate the number of months of actual expenses (minimum of six months) and the number of months of estimated expenses in the current fiscal year.

Exhibit 17

Instructions for Completing Budget Forms

Form A—Self-explanatory.

Form B—Self-explanatory.

Form C—Departmental Summary and Per Diem Calculation:

(1) Detailed figures reported should be budgeted figures only.

(2) Amounts reported as Salaries & Wages-Employees & Fees, and Supplies & Expenses should agree in total with the amounts reported on the budgeted detailed expense schedules (Forms E, F, and G).

(3) The per diem amounts should be based on the total budgeted patient days as reported on Form D.

(4) The paid hours should agree with the total of hours as reported on the detailed Form E.

(5) The requested operating statistics should be completed in accordance with the detailed notes on Form C, Page 5 and should be based on the amounts and hours as reported on Form C.

Form D—The regularly maintained number of beds represents the *average* number of beds available, set up and staffed for use during the applicable year.

Form E—Salaries & Wages-Employees & Fees:

(1) The number of full-time equivalent employees (FTE) should be determined by dividing the paid hours by 2080 annual hours per employee.

Exhibit 17

The number of salaried employees, and/or physicians on a fee basis for which paid hours are not recorded shall be included in the FTE, calculated by adding 2080 hours for each such full-time person and the part of 2080 hours represented by the percent of time spent in hospital activities for each such part-time person.

(2) Indicate the number of actual and estimated months used in arriving at the projected expenses for the current year.

(3) The total amount on Page 7, Line 93 should be carried forward to Form A, Line 1.

Form F—Supplies & Expenses:

(1) Indicate the number of actual and estimated months used in arriving at the projected expenses for the current year.

(2) The total amount on Page 7, Line 91 should be carried forward to Form A, Line 2.

(3) The total amount of interest expense on Page 7, Line 94 should be carried forward to Form A, Line 4.

Form G—Depreciation Expense:

(1) For Blue Cross purposes, only straight line method of depreciation is permitted.

(2) The total amount of depreciation on Form G, Line 9 should be carried forward to Form A, Line 3.

Exhibit 17

Form H—Analysis of Recovery of Expense Items:

(1) The totals on Form H, Line 16 should be carried forward to Form A, Line 6.

Form I—Self-explanatory.

Form J—Self-explanatory.

Form K—Comparative Report Educational Expenses:

The purpose of this Form is to determine the amount of educational expense allowable for reimbursement purposes within the limitations set forth in the "Hospital Agreement."

(1) Salaries and fees are the totals including those charged directly to the teaching program, to various cost centers, etc. Portions of salaries and fees paid to those individuals which are not related to intern and residence programs are to be excluded.

(2) Fringes and/or perquisites are those which are *not* furnished all other employees; e.g. value of living accommodations, meals, laundry, drugs, use of automobile, etc., but excluding malpractice insurance.

FORM A

Date Submitted: _____

B. C. Code No. _____

Percentage Variances Budget vs.		
Actual	Projected	
%	%	

OPERATING BUDGET
Summary of Costs

_____ (HOSPITAL)

Fiscal Year: _____

TOTAL OPERATING EXPENSES:	ACTUAL Amount	ACTUAL %	PROJECTED Amount	PROJECTED %	BUDGET Amount	BUDGET %
1. Salaries & Wages—Employees & Fees (From Form E, line 93)	$		$		$	100%
2. Supplies & Expenses (From Form F, line 91)						
3. Depreciation (From Form G, line 9)						
4. Interest on Indebtedness (From Form F, line 94)						
5. TOTAL Expenses		100%		100%	$	100%
Less Deductions and Recoveries:						
6. Items of income which are recovery of expenses (From Form H, line 16)						
7. Less: Research (From Form E, line 91 plus Form F, line 75)						
8. Less: Non-Reimbursable Functions (From Form E, line 92 plus Form F, line 76)						
9. Less: Non-Allowable Educational Expense (From Form K, line 14)						
10. Less: Home Care (From Form E, line 69 plus Form F, line 52)						
11. Less: Extended Care (From Form E, line 39 plus Form F, line 51)						
12. Less: Other: (Explain)						
13.						
14. TOTAL Deductions	$		$		$	
15. TOTAL Patient Care Expenses Net	$		$		$	

I certify that this Budget has been reviewed and approved by the governing body of this institution.

_____ (Date) _____ (Signature) _____ (Title)

Exhibit B

OPERATING BUDGET
Calculation of Tentative Blue Cross Gross Payment Rate

FORM B 230a

Date Submitted: _____

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	ACTUAL	PROJECTED	BUDGET	Percentage Variances Budget VS. (Note 3) Actual	Percentage Variances Budget VS. (Note 3) Projected
1. Total Patient Care Expenses Net (Form A, line 15)	$	$	$	%	%
2. Less: Depreciation Expense (Form A, line 3)					
3. Total Patient Care Expenses Net-Less: Depreciation (Line 1 –line 2)					
4. Less: Out Patient Expenses (Note 1)	$	$	$		
5. Total Modified In Patient Expense (Line 3 –line 4)					
6. Total In Patient Days (Excluding Newborn)					
7. Average Per Diem Modified In Patient Expense (Line 5 ÷ line 6)					
8. In Patient Portion of Depreciation Expense (Note 2)	$	$	$		
9.					
10. Average Per Diem Depreciation In Patient Expense (Line 8 ÷ line 6)					
11. TOTAL Average Per Diem In Patient Expenses (Line 7 + line 10)	$	$	$		

Note 1—Out Patient expenses to be calculated on the ratio of the previous years out patient expenses to total expenses per Blue Cross Cost Report Schedule C applied to Line 3 above.

Note 2—Depreciation expenses to be calculated on the ratio of the previous years in patient expenses to total expenses per Blue Cross Cost Report Schedule C, applied to amount of depreciation expense in Line 2.

Note 3—Attach any necessary supplemental data required to explain percentage increase in excess of contract limitation.

Exhibit B

Exhibit 17

OPERATING BUDGET
Departmental Summary and Per Diem Calculation

FORM C
Page 1 of 5

Date Submitted: _____

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	BUDGETED COSTS: Salaries & Wages—Employees and Fees Amount	Salaries & Wages—Employees and Fees Per Diem	Supplies & Expenses (Forms F & G) Amount	Supplies & Expenses (Forms F & G) Per Diem	Budgeted Total Costs Amount	Budgeted Total Costs Per Diem	Paid Hours (Form E)	Operating Departmental Statistics
1. ADMINISTRATIVE AND GENERAL								
Executive offices	$	$	$	$	$	$		
Accounting & Fiscal								
All other Administrative Expenses								
TOTAL	$	$	$	$	$	$		
Direct Cost Per Bed (note 1)								
Manhours Per Bed (note 2)								
2. DIETARY								
Number of Meals Served								
Direct Cost Per Meal								
Meals Served Per Manhour								
3. PLANT								
Number of square feet								
Direct Cost Per 1000 square feet								
Direct Cost Per Bed (note 1)								
Manhours Per 1000 square feet								
4. HOUSEKEEPING								
Number of square feet								
Direct Cost Per 1000 square feet								
Direct Cost Per Bed (note 1)								
Manhours Per 1000 square feet								

Exhibit B

Exhibit 17

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OPERATING BUDGET
Departmental Summary and Per Diem Calculation

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	BUDGETED COSTS							Operating Departmental Statistics
	Salaries & Wages—Employees and Fees		Supplies & Expenses (Forms F & G)		Budgeted Total Costs		Paid Hours (Form E)	
	Amount	Per Diem	Amount	Per Diem	Amount	Per Diem		
5 MAINTENANCE OF PERSONNEL	$	$	$	$	$	$		
6 LAUNDRY AND LINEN								
Laundry Direct Cost Per 100 lbs.								
Laundry lbs. Per Manhour								
Laundry lbs. Per Patient Day								
Laundry and Linen D. C. Per Bed (note 1)								
7 TOTAL NURSING SERVICE								
OB Manhours Per Bed Per Day (note 3)								
Med. Surg. Manhours Per Bed Per Day (note 3)								
All other Manhours Per Bed Per Day (note 3)								
TOTAL Nursing Manhours Per Bed Per Day (note 3)								
8 CENTRAL STERILE SUPPLY								
Direct Cost Per Bed (note 1)								
9 DELIVERY ROOM & POST PARTUM RECOVERY								
Number of Deliveries								
Direct Cost Per Delivery								
Manhours Per Delivery								
10 OPERATING ROOM & CYSTOSCOPY								
Number of Operations								
Direct Cost Per Operation								
Manhours Per Operation								

Exhibit B

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Exhibit 17

OPERATING BUDGET
Departmental Summary and Per Diem Calculation

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	BUDGETED COSTS							Operating Departmental Statistics
	Salaries & Wages—Employees and Fees		Supplies & Expenses (Forms F & G)		Budgeted Total Costs		Paid Hours (Form E)	
	Amount	Per Diem	Amount	Per Diem	Amount	Per Diem		
11 RECOVERY ROOM	$	$	$	$	$	$		
12 LABORATORY								
13 BLOOD BANK								
14 X-RAY DEPT. INCLUDING X-RAY THERAPY, AND ISOTOPE THERAPY								
Manhours per procedure								
Direct cost per procedure								
15 PHARMACY								
16 MEDICAL RECORDS AND LIBRARY								
Direct cost per bed (note 1)								
Manhours per bed (note 2)								
17 ANESTHESIOLOGY								
18 INHALATION THERAPY								
19 EMERGENCY ROOM								
20 AMBULANCE SERVICE								
21 CLINICS								

Exhibit B

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Exhibit 17

OPERATING BUDGET
Departmental Summary and Per Diem Calculation

(HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	BUDGETED COSTS						Paid Hours (Form E)	Operating Departmental Statistics
	Salaries & Wages—Employees and Fees		Supplies & Expenses (Forms F & G)		Budgeted Total Costs			
	Amount	Per Diem	Amount	Per Diem	Amount	Per Diem		
22. ALL OTHER PROFESSIONAL SERVICES	$	$	$	$	$	$		
Physical Therapy								
Social Service								
Home Health Care								
Day Nursery								
Electrocardiograph								
Electroencephlagraph								
Medical Photography & Illustration								
Speech Therapy								
Occupational & Recreational Therapy								
Extended Care								
23. MEDICAL EDUCATION								
(should agree with Form K, line 13)								
24. PARA-MEDICAL EDUCATION								
School of Nursing (R.N.)								
Other Education								
Direct Cost Per Bed (note 1)								
25. RESEARCH EXPENSES								
26. NON-REIMBURSABLE FUNCTIONS								

Exhibit B

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Exhibit 17

OPERATING BUDGET
Departmental Summary and Per Diem Calculation

(HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	BUDGETED COSTS						Paid Hours (Form E)	Operating Departmental Statistics
	Salaries & Wages—Employees and Fees		Supplies & Expenses (Forms F & G)		Budgeted Total Costs			
	Amount	Per Diem	Amount	Per Diem	Amount	Per Diem		
27. NON-DEPARTMENTAL EXPENSES	$	$	$	$	$	$		
Payroll Taxes								
Fire, Liability, Malpractice & Other Insurance								
Group Life								
Hospitalization								
Major Medical								
Workmens Compensation								
Unemployment Insurance								
Tuition Refund								
Pension Costs								
Taxes Other than Payroll								
Other								
Interest—Capital Debt								
Interest—Working Capital Debt								
Depreciation								
28. TOTAL (should agree with amounts reported on Forms E, F, & G)								

Note 1—This is a monthly statistic and is calculated by multiplying the total of regularly maintained beds by 12 months and dividing the result into the total budgeted costs.

Note 2—This is a monthly statistic and is calculated by multiplying the total of regularly maintained beds by 12 months and dividing the result into the total paid hours.

Note 3—This is a daily statistic and is calculated by multiplying the total number of regularly maintained beds by 365 days and dividing the result into the total paid hours.

Exhibit B

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Exhibit 17

NOTE: Refer AHA Uniform Definitions (1960) for explanation of statistical terms.

OPERATING BUDGET
Statistics

FORM D
Page 1 of 3

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Date Submitted: _____

B. C. Code No. _____

_____
(HOSPITAL)

Fiscal Year: _____

	Number of Beds Regularly Maintained	Total Patient Admissions	Total Patient Days	Average Length Of Stay	Percent Occupancy
Actual ____					
Major Services:					
Medical—Surgical					
Pediatric					
Psychiatric					
Obstetric (excludes Nursery)					
Total Acute Care					
Extended Care					
Grand TOTAL					
Projected ____ ____ Months Actual ____ Months Estimated					
Major Services:					
Medical—Surgical					
Pediatric					
Psychiatric					
Obstetric (excludes Nursery)					
Total Acute Care					
Extended Care					
Grand TOTAL					
Budget ____					
Major Services:					
Medical—Surgical					
Pediatric					
Psychiatric					
Obstetric (excludes Nursery)					
Total Acute Care					
Extended Care					
Grand TOTAL					

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Exhibit 17

Exhibit B

OPERATING BUDGET
Statistics

FORM D
Page 2 of 3

_____
(HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

Service	Total	Inpatients	%	Outpatients	%
Laboratory Operations					
Clinical Lab Test:					
Actual ____					
Projected ____					
Budget ____					
Pathological Exams:					
Actual ____					
Projected ____					
Budget ____					

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Exhibit 17

Radiological Operations					
Diagnostic X-Ray Procedures					
Actual ____					
Projected ____					
Budget ____					
Therapeutic X-Ray Procedures					
Actual ____					
Projected ____					
Budget ____					
Radio-Isotope Procedures					
Actual ____					
Projected ____					
Budget ____					

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Exhibit B

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OPERATING BUDGET
Statistics

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

Clinic Statistics	Number of Clinics Operated	Total Clinic Hours Scheduled Weekly	Number of Visits Annually	No. of Patients Treated Annually
Actual ____				
Projected ____				
Budget ____				

Private Ambulatory Statistics	Total Number of Visits
Actual ____	
Projected ____	
Budget ____	

Emergency Room Statistics	Total Number of Visits
Actual ____	
Projected ____	
Budget ____	

Number of Operations	Total Number
Actual ____	
Projected ____	
Budget ____	

Exhibit B

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Exhibit 17

OPERATING BUDGET
Salaries & Wages—Employees & Fees

Date Submitted: _____

B. C. Code No. _____

_____ (HOSPITAL)

Fiscal Year: _____ _____

	____ ACTUAL			____ PROJECTED ____ Months Actual ____ Months Est.			____ BUDGET		
	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE
1. A. SERVICE DEPARTMENTS									
2. Administrative & General:									
3. Executive Offices									
4. Accounting and Fiscal Services									
5. All Other Administrative									
6.									
7.									
8.									
9.									
10.									
11.									
12.									
13. TOTAL Administrative & General									
14.									
15. Dietary (including Cafeteria)									
16.									

Exhibit B

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Exhibit 17

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OPERATING BUDGET
Salaries & Wages—Employees & Fees

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

		ACTUAL			PROJECTED ____ Months Actual ____ Months Est.			BUDGET		
		Amount	Paid Hours	FTE	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE
17.	PLANT:									
18.	Maintenance									
19.	Operation of Plant									
20.	Motor Service									
21.	Security									
22.	TOTAL Plant									
23.										
24.	Housekeeping									
25.	Maintenance of Personnel (Personnel Quarters)									
26.										
27.	Laundry									
28.	Linen, Bedding & Sewing Room									
29.	TOTAL Service Departments									

Exhibit B

Exhibit 17

OPERATING BUDGET
Salaries & Wages—Employees & Fees

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

		ACTUAL			PROJECTED ____ Months Actual ____ Months Est.			BUDGET		
		Amount	Paid Hours	FTE	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE
30.	B. PROFESSIONAL CARE OF PATIENTS									
31.	Nursing Service:									
32.	Nursing Service Administration									
33.	Obstetrics									
34.	Medical and Surgical									
35.	Intensive Care & Coronary Care Units									
36.	Pediatrics									
37.	Nursery									
38.	Psychiatric									
39.	Extended Care									
40.										
41.										
42.	TOTAL Nursing Service									
43.										
44.	Central Sterile Supply									

Exhibit B

Exhibit 17

OPERATING BUDGET
Salaries & Wages—Employees & Fees

FORM E
Page 4 of 7

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

		____ ACTUAL			____ PROJECTED ____ Months Actual ____ Months Est.			____ BUDGET		
		Amount	Paid Hours	FTE	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE
45.	Delivery Room & Post Partum Recovery									
46.	Operating Room & Cystoscopy									
47.	Recovery Room									
48.										
49.	Laboratories									
50.	Blood Bank									
51.	Medical Photography & Illustration									
52.	Diagnostic X-Ray									
53.	X-Ray Therapy									
54.										
55.	Radio—Isotopes									
56.	Renal Dialysis									
57.										
58.	Pharmacy									
59.	Medical Records									

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Exhibit 17

Exhibit B

OPERATING BUDGET
Salaries & Wages—Employees & Fees

FORM E
Page 5 of 7

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

		____ ACTUAL			____ PROJECTED ____ Months Actual ____ Months Est.			____ BUDGET		
		Amount	Paid Hours	FTE	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE
60.	Medical Library									
61.	Anesthesiology									
62.	Inhalation Therapy									
63.	Electroencephlagraph									
64.	Electrocardiograph									
65.										
66.	Physical Therapy									
67.	Speech Therapy									
68.	Occupational & Recreational Therapy									
69.	Home Health Care									
70.	Social Service									
71.	Emergency Room									
72.	Clinics									
73.	Ambulance Service									

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Exhibit 17

Exhibit B

OPERATING BUDGET
Salaries & Wages—Employees & Fees

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	ACTUAL			PROJECTED _____ Months Actual _____ Months Est.			BUDGET		
	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE
74.									
75.									
76.									
77.									
78.									
79. TOTAL Professional Services									
80. Medical Education (should agree with Form K, line 13)									
81.									
82. C. PARA-MEDICAL EDUCATION									
83. School of Nursing									
84. School of Practical Nursing									
85. In-Service Education									
86. School of Medical Technology									

OPERATING BUDGET
Salaries & Wages—Employees & Fees

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	ACTUAL			PROJECTED _____ Months Actual _____ Months Est.			BUDGET		
	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE	Amount	Paid Hours	FTE
87. School of X-Ray Technology									
88.									
89.									
90. TOTAL Para-Medical Education									
91. Research									
92. Non Reimbursable Functions									
93. TOTAL Salary & Wages—Employees & Fees (To Form A, line 1)	$			$			$		

OPERATING BUDGET
Supplies & Expenses

FORM F
Page 1 of 7

Date Submitted: _____

_____
(HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	____ ACTUAL	____ PROJECTED ____ Months Actual ____ Months Projected	____ BUDGET
1. SERVICE DEPARTMENTS			
2. Executive			
3. Accounting & Fiscal			
4. All other Administrative			
5. TOTAL Administrative			
6. Dietary (including Cafeteria)			
7. Plant			
8. Housekeeping			
9. Maintenance of Personnel (Personnel Quarters)			
10. Laundry			
11. Linen, Bedding & Sewing Room			
12.			
13.			
14. TOTAL Service Departments			
15.			

Exhibit B

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Exhibit 17

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OPERATING BUDGET
Supplies & Expenses

FORM F
Page 2 of 7

_____
(HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	____ ACTUAL	____ PROJECTED ____ Months Actual ____ Months Projected	____ BUDGET
16. PROFESSIONAL CARE OF PATIENTS:			
17. Nursing Service			
18. Central Sterile Supply			
19. Delivery Room & Post Partum Recovery			
20. Operating Room & Cystoscopy			
21. Recovery Room			
22. Laboratories			
23. Blood Bank			
24. Medical Photography & Illustration			
25. Renal Dialysis			
26.			
27.			
28.			
29. Diagnostic X-Ray			
30. X-Ray Therapy			
31.			

Exhibit B

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Exhibit 17

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OPERATING BUDGET
Supplies & Expenses

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	____ ACTUAL	____ PROJECTED ____ Months Actual ____ Months Projected	____ BUDGET
32. Radio—Isotopes			
33.			
34.			
35.			
36. Pharmacy			
37.			
38. Medical Library			
39. Medical Records			
40.			
41.			
42. Anesthesiology			
43. Inhalation Therapy			
44. Electroencephlagraph			
45. Electrocardiograph			
46.			

Exhibit 17

Exhibit B

OPERATING BUDGET
Supplies & Expenses

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	____ ACTUAL	____ PROJECTED ____ Months Actual ____ Months Projected	____ BUDGET
47. Physical Therapy			
48. Speech Therapy			
49. Social Service			
50. Occupational and Recreational Therapy			
51. Extended Care			
52. Home Health Care			
53. Emergency Room			
54. Ambulance Service			
55. Clinics			
56.			
57.			
58.			
59.			
60.			
61.			

Exhibit 17

249a

ExHibit B

250a

OPERATING BUDGET
Supplies & Expenses

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	____ ACTUAL	____ PROJECTED ____ Months Actual ____ Months Projected	____ BUDGET
62. Medical Education (should agree with Form K, line 13)			
63.			
64.			
65. TOTAL Professional Care of Patient Expenses			
66. PARA-MEDICAL EDUCATION:			
67. School of Nursing			
68. School of Practical Nursing			
69.			
70. In-Service Education			
71. School of Medical Technology			
72. School of X-Ray Technology			
73.			
74. TOTAL Para-Medical Education			
75. Research Expenses			

B-25

Exhibit 17

Exhibit B

OPERATING BUDGET
Supplies & Expenses

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	____ ACTUAL	____ PROJECTED ____ Months Actual ____ Months Projected	____ BUDGET
76. Non Reimbursable Functions			
TOTAL DEPARTMENTAL EXPENSES (Lines 1-76)			
NON-DEPARTMENTAL EXPENSES			
77. Payroll Taxes			
78. Fire, Liability, Malpractice & Other Insurance			
79. Group Life			
80. Hospitalization			
81. Major Medical			
82. Workmen's Compensation			
83. Unemployment Insurance			
84. Tuition Refund			
85. Pension Costs			
86. Taxes Other than Payroll			
87. Other			

B-26

Exhibit 17

251a

Exhibit B

252a

OPERATING BUDGET
Supplies & Expenses

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

	____ ACTUAL	____ PROJECTED ____ Months Actual ____ Months Projected	____ BUDGET
88.			
89.			
90. TOTAL NON-DEPARTMENTAL EXPENSES			
91. TOTAL SUPPLIES & EXPENSES (To Form A, line 2)			
92. Interest Expense—Capital Indebtedness			
93. Interest Expense—Working Capital Indebtedness			
94. TOTAL INTEREST EXPENSE (To Form A, line 4)			

Note: Indicate Cost Center to which IV's are charged

B-27

Exhibit 17

Exhibit B

OPERATING BUDGET
Depreciation Expense

FORM G

Date Submitted: _____

B. C. Code No. _____

_____ (HOSPITAL)

Fiscal Year: _____

	____ ACTUAL		____ PROJECTED		BUDGET	
	Method	Amount	Method	Amount	Method	Amount
1. Land Improvements		$		$		$
2. Buildings						
3. Fixed Equipment						
4. Automobiles and Trucks						
5. Major Movable Equipment						
6. Leasehold Improvements						
7. Minor Equipment						
8. Other						
9. TOTAL (To Form A, Line 3)		$		$		$

B-28

Exhibit 17

253a

Exhibit B

OPERATING BUDGET
Analysis of Recovery of Expense Items

FORM H

Date Submitted: _____

_____ (HOSPITAL) B. C. Code No. _____

Fiscal Year: _____

ITEM	ACTUAL	PROJECTED	BUDGET
1. Telephone	$	$	$
2. Laundry Services			
3. Nurses', Guest' & Employees' Meals			
4. Rental of Quarters			
5. Income from Nurses' Training Schools			
6. Sales of Supplies (To Doctors & Employees)			
7. Rebates & Quantity Discounts			
8. Nurses' Registry Fees			
9. Medical Transcript Fees			
10. Other (List Below)			
11			
12			
13			
14			
15			
16. TOTAL (To Form A, line 6)	$	$	$

Exhibit B

OPERATING BUDGET
Personnel Policies

FORM I
Page 1 of 2

Date Submitted: _____

_____ (HOSPITAL) B. C. Code No. _____

Fiscal Year: _____

1. Indicate the current minimum hiring wage your institution is paying for unskilled labor.

RATE $ _____

2. Are there any plans to increase the above minimum wage during the budgeted period, please explain below.

_____

_____

_____

_____

3. Indicate the beginning rate on July 1 of budgeted year for the following personnel classifications:

Interns	$	Annually
Residents		Annually
Registered Nurses		Annually
Licensed Practical Nurses		Annually
Nursing Aides		Hourly
Orderlies		Hourly

4. Does the hospital provide any housing for employees? Indicate type of housing, number of units, any income, etc.

_____

_____

5. On what date do your employees receive their annual merit adjustments, i.e., employment anniversary, July 1, other ?

_____

6. Outline briefly union contracts in force. Include names of unions, number of employees in each bargaining unit and expiration date of contracts.

_____

_____

_____

_____

Exhibit B

OPERATING BUDGET
Personnel Policies

FORM I
Page 2 of

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

7 Nursing Service Complement

	FTE	Percent
RN's		
LPN's		
Aides		
All Other Nursing Personnel		
TOTAL—Per Form E, line 42		100%

8 How many hours constitute the regular work week? _____

Briefly explain the following policies of your hospital, or submit a copy of your personnel policies

9 Premium Pay — Overtime _____
— On call pay
— Shift differential
— Call back Allowance

10 Number of holidays granted each year _____

11 Briefly explain vacation policy _____

12 Employee benefits (indicate whether contributory or non-contributory) _____

13 Sick leave benefits _____

Exhibit B

OPERATING BUDGET
Supplemental Questionnaire

FORM J
Page 1 of 2

Date Submitted: _____

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

1. Indicate by check those services or programs in which you participate:

	YES	NO
H.A.S. (Hospital Administrative Services)		
P.A.S. (Professional Activity Study)		
M.A.P. (Medical Audit Program)		
P.A.T. (Pre-Admission Testing)		
OB/GYN mixing		
H.U.P. (Hospital Utilization Program)		
S.P.U. (Short Procedure Unit)		
M.C.U. (Minimal Care Unit)		

2. Indicate status of prior years cost filings with third parties (not amounts due)

	Blue Cross	Medicare	Medicaid
1967			
1968			
1969			
1970			
1971			
1972			

3. Indicate any service contracts which the hospital has for the performance of Patient Care Services, Data Processing, Dietary, Housekeeping, Laundry, etc.

_____

Exhibit B

OPERATING BUDGET
Supplemental Questionnaire

_____ (HOSPITAL)

B. C. Code No. _____

Fiscal Year: _____

4. Indicate any rentals and leases in excess of $5,000 per annum.

5. List any new facilities, programs, or services, since July 1, 1971. Indicate the approximate annual direct costs (salaries and supplies) included in the 197 budget for these programs or services and whether approval of an appropriate Planning Agency, if necessary, was obtained.

6. Do you have approved intern and residency programs ? ☐ yes ☐ no. If yes, please list below:

7. Please attach a copy of most recent audited Financial Statement.

8. List hospital based ancillary services which bill separately from hospital billing. _____

Exhibit B

FORM K

OPERATING BUDGET
Comparative Report Educational Expenses

Date Submitted: _____

B. C. Code No. _____

_____ (HOSPITAL)

Fiscal Year: _____

PERSONNEL: Number F.T./P.T.	_____ ACTUAL				_____ PROJECTED				_____ BUDGET				Percentage Variance Budget vs.	
	Salaries and Fees	Fringes and Perquisites	Supplies and Expenses	Total Expenses	Salaries and Fees	Fringes and Perquisites	Supplies and Expenses	Total Expenses	Salaries and Fees	Fringes and Perquisites	Supplies and Expenses	Total Expenses	Actual	Proj.
1. Interns	$													
NUMBER FT /P T	F.T. P.T.				F.T. P.T.				F.T. P.T.					
2. Residents	$													
NUMBER FT /P T	F.T. P.T.				F.T. P.T.				F.T. P.T.					
3. Director Med. Ed.	$													
NUMBER FT /P T	F.T. P.T.				F.T. P.T.				F.T. P.T.					
4. Sec'y. & Clerks	$													
NUMBER FT /P T	F.T. P.T.				F.T. P.T.				F.T. P.T.					
5. Teaching M.D.'s	$													
NUMBER FT /P T	F.T. P.T.				F.T. P.T.				F.T. P.T.					
6. Others:	$													
NUMBER FT /P T	F.T. P.T.				F.T. P.T.				F.T. P.T.					
7. Total Expenses	$													
NUMBER FT /P T	F.T. P.T.				F.T. P.T.				F.T. P.T.					
EXPENSE OFFSETS 8. Grants	$													
9. Fellowships	$													
10. Income-Affiliates	$													
11. Others:	$													
12. Total Offsets	$													
13. Total Net Expenses	$													
14. Total Net Expenses in Excess of Contract Limitation (Attach Detailed Calculation) $														

Exhibit B

Exhibit 17

EXHIBIT C

HOSPITAL SAFETY PROGRAM

In accordance with Section 20 of this Agreement, the Provider agrees to establish a safety program incorporating, as practicable and appropriate, the following principles:

Section 1. Management Involvement.

(a) The basic program shall incorporate procedures designed to foster loss control and malpractice prevention, and shall be communicated in written form to key hospital personnel.

(b) Plans to implement the program and periodic progress reports shall be included on the agenda of top level management meetings.

(c) A Safety Committee shall be formed to include at least one trustee, administrative personnel, at least one physician, and other appropriate persons.

Section 2. Education.

(a) The Safety Committee shall review incidents threatening the safety of patients.

(b) The Provider shall instruct medical personnel as regards the nature and legal implications of malpractice.

Section 3. Policies and Standards for Reporting Incidents.

All incidents or unusual occurrences threatening the safety of patients shall be reported in writing to the chief administrative officer, or his designee, and the Safety Committee.

Exhibit 17

Section 4. Accident Investigation.

The chief administrative officer, or his designee, shall make prompt investigation of all non-medical incidents and the chief medical officer, or his designee, shall investigate all medical incidents. The Safety Committee shall take appropriate steps to prevent assertions of malpractice and develop appropriate policies to implement such practice.

Section 5. Facility Inspections.

The chief administrative officer, or his designee, shall inspect Provider's facilities regularly giving particular attention to equipment involved in critical patient care. All deficiencies or malfunctions shall be reported along with the corrective action taken. Medical personnel shall be designated to periodically inspect equipment involved in critical patient care.

Section 6. Supervisory Training.

Procedures shall be established for the training of not only supervisory personnel, but all employees shall be included in the safety program.

Section 7. Group Meetings.

Safety meetings shall be held periodically by each department of the Provider.

Section 8. Personnel Protection.

The Provider shall provide protective equipment to appropriate personnel and ensure that such is periodically inspected.

Exhibit 17

Section 9. Contract Review.

Purchasing arrangements, including arrangements for the purchase of drugs being used for experimental purposes, shall be carefully reviewed to ensure that suppliers have assumed responsibility for inherent defects in their products.

Section 10. Other Loss Control Programs.

Programs shall be established to control and eliminate fire hazards, workmen's compensation losses, liability losses and other types of avoidable expenses.

Exhibit 18

HOSPITAL AGREEMENT

July 1, 1971

Amendment Effective July 1, 1972

The parties hereto, intending to be legally bound hereby, agree that the Hospital Agreement dated July 1, 1971 to which they are parties (the "Agreement"), shall be amended as follows:

1. *Subsection 18.4.6 is deleted in its entirety and the following inserted in its place:*

18.4.6. Subject to the requirements set forth in subsections 18.2, 18.3 and 18.4 hereof and subsection 1.4 of Exhibit A, Part I, the maximum total allowable cost to be used as the basis for calculating the reimbursement to be paid Provider by Blue Cross for the fiscal year 1972-1973 shall be limited to the total actual allowable costs of Provider approved by Blue Cross for the fiscal year 1971-1972, plus such increase as may be permitted by the applicable limitations promulgated pursuant to the Economic Stabilization Act, as amended. Any such increase shall be permitted Provider if the item producing the increase is allowable as a reimbursable cost under the Agreement as amended hereby and is (i) specifically allowed upon review by the authorized regulatory body having appropriate jurisdiction over hospital price increases, or (ii) generally allowed hospitals without need for specific approval. In requesting any such increase, Provider agrees to furnish Blue Cross with all pertinent supporting data and to annualize such so that appropriate line comparisons may be made with the applicable prior fiscal years.

In the event public notice is given by the Federal government that the price controls imposed on Provider pursuant to the Economic Stabilization Act, as amended,

Exhibit 18

are to be abondoned, discontinued or otherwise terminated, Blue Cross and Provider, or its designee, shall meet within five business days after the date of such notice to negotiate an alternative maximum total allowable cost which shall be effective as of the date the aforesaid price controls were terminated. Unless agreement as to such alternative maximum total allowable cost be reached within thirty days immediately following the date of notice that the price controls imposed on Provider are to be terminated the Agreement shall terminate subject to Section 27 thereof provided, however, that the 90 day period set forth in Section 27 of the Agreement shall in such event be reduced to 60 days. The interim rates for the period following the date the price controls are discontinued or otherwise terminated shall be those interim rates which were in effect at the date of said termination until such later date as the Agreement is amended to reflect a negotiated alternative maximum total allowable cost.

2. *Except as amended hereby, the Agreement and all other provisions thereof shall remain in full force and effect, and the execution of this Amendment shall constitute execution of the Agreement as so amended, effective as of July 1, 1972.*

Exhibit 18

IN WITNESS WHEREOF, the parties hereto, intending to be legally bound, have caused these presents to be executed by their proper officers as of the date of execution set forth below.

Date of Execution

_____

Effective Date

July 1, 1972

_____
Name of Provider

By _____
Signature

_____
Title of Signing Officer

BLUE CROSS OF GREATER PHILADELPHIA

By _____
President

Exhibit 19

BLUE CROSS OF GREATER PHILADELPHIA

1333 Chestnut Street, Philadelphia, Pennsylvania 19107

December 29, 1972

Mr. Clarence H. Warden, Jr., Chairman
Delaware Valley Hospital Council
311 South Juniper Street
Philadelphia, Pennsylvania 19107

Dear Clarence:

As we are all aware, the current "Hospital Agreement" automatically terminates on June 30, 1973. Although there is no specific date by which discussions on a replacement contract are required to start under the "Hospital Agreement", the previous contract specified six months prior to termination, and you alluded to the matter of negotiations during our most recent meeting on intern and resident cost.

We are most anxious that the new contract be complete, approved and in the hands of the hospitals before July 1, 1973 in order to avoid the impairment of the hospitals' cash flow, as it was last year.

We believe that our negotiations can be expedited if all parties study and evaluate those various items and concepts which might be considered for inclusion in the replacement contract and that we lay the groundwork for future discussions by a prompt preliminary informal exchange of our collective thoughts and suggestions. To this end we are enclosing a summary of the current Insurance Department's "Guidelines" [*see* Exhibit 15, *infra*], many of which have been incorporated in the present contract, and are listing below a few of our thoughts which we hope you will explore and comment on:

1. Utilization review does not seem to be controlling unnecessary hospitalization at all hospitals.

Exhibit 19

This includes not only necessity and timeliness, but also the control and planning of discharge and management of patient care.

2. Identifying and justifying those areas of individual hospital's activities which appear from financial data to be unnecessarily expensive. It might involve Blue Cross arranging for onsite studies of specific areas.

3. Reducing the per capital project amount requiring approval by the Hospital Survey Committee, Inc. to coincide with that of H.R. 1.

4. Specific means for protecting patients from the exorbitant cost of the building of under-financed and/or excessively expensive facilities.

5. Underutilized facilities which are not voluntarily taken out of service.

6. Positive prevention of potential double payment by Blue Cross and Blue Shield or Blue Cross and subscribers.

7. Staffing levels.

8. Methods to improve Hospital Trustee public accountability.

9. More effective cost containment measures.

Also, we invite your review of the recently published "Study of Health Facilities Construction Costs" by the Comptroller General of the United States in a Report to the Congress of the United States dated December, 1972 which contains many suggestions for cost containment of the health care delivery system.

Exhibit 19

We hope that Council will provide us with input on the various subjects listed above and would also welcome similar suggestions of other specific areas Council wishes to explore.

Sincerely yours,

/s/ BRUCE TAYLOR

BRUCE TAYLOR
President

Exhibit 20

SUMMARY OF PRINCIPLES TO BE UTILIZED IN DRAFTING AN INTERIM 1973 HOSPITAL AGREEMENT

I. The 1971 Hospital Agreement, except where the parties have specifically negotiated changes, shall be utilized as the basic guide in drafting the 1973 Interim Hospital Agreement.

Marked success has been achieved in the Greater Philadelphia area during the past two years in stablizing costs and improving the health care delivery system. This progress suggests the advisability of continuing the 1971 Hospital Agreement, except where changes designed to provide a more viable health care delivery system to serve the needs of the Delaware Valley area community have been negotiated by the parties and are set forth herein. In drafting the new agreement, the 1971 Hospital Agreement will be utilized as a basis, augmented where appropriate to incorporate changes developed by the negotiating parties after consideration of suggestions by the Providers, Blue Cross, the American Hospital Association, Joint Commission on Accreditation of Hospitals, Pennsylvania Insurance Department, and appropriate statutes and regulations.

II. The Utilization Review Program described in Section 11 of the 1971 Hospital Agreement shall be modified to provide for prompt initial review of all hospitalizations, and continuing review and monitoring of hospitalization.

The utilizat on review program to be implemented by all Providers shall include prompt review and establishment of an expected length of stay for all

hospitalizations, whether elective or not, within 60 hours after admission until June 30, 1975, and thereafter within 48 hours after admission (excluding Saturdays, Sundays and holidays).

Blue Cross may retrospectively deny, in whole or in part, any admission or length of stay based upon a determination of medical appropriateness, as hereinafter defined. In the event of an appeal by a physician, or an unresolved difference regarding the medical appropriateness of a hospitalization between Blue Cross and a Provider, the review procedures set forth in Subsection 2.3 of the 1971 Hospital Agreement shall be employed. In this regard, it may be desirable to develop formal review procedures for use by the reviewing county medical societies to ensure continuity and comparability of review.

For purposes of the foregoing, the term "medical appropriateness" shall be interpreted to mean:

1. Hospitalization which is provided at the situs level furnishing necessary Covered Services at the lowest cost consistent with the services rendered.

2. Hospitalization limited in scope and extent to that medically justified by the diagnosis and particular patient's condition.

3. Hospitalization limited in length of stay to that required by the patient's diagnosis as reviewed and approved by the Utilization Review Committee.

4. Hospitalization which is medically required and consistent with the requirements of the: (a) Public Law 89-97, as amended by P.L. 92-603, (b) Pre-Discharge Utilization Review program of the Commonwealth of Pennsylvania for recipients under

the Title XIX Medicaid Program, (c) Pennsylvania Department of Public Welfare as promulgated in the Welfare Assistance Manual at Section 9421.52, and (d) Joint Commission on Accreditation of Hospitals.

III. The present appeal procedure shall be modified to provide for immediate judicial proceedings unless the parties to an unresolved controversy immediately select an appeals board and submit the matter to binding arbitration by it.

The rules and regulations to be followed in cases involving voluntary binding arbitration have not been discussed at length but would generally follow those of the American Arbitration Association applicable to Commercial Arbitration.

IV. A uniform method of current financing will be developed to make payment of Blue Cross reimbursement in the most expeditious basis administratively feasible, encourage prompt billing by hospitals, and provide for advances, if appropriate. In the alternative, a Provider may elect the Medicare Periodic Interim Payment Program.

In order to develop an expedited payment procedure, an improved method will be instituted which essentially will provide for current payment of approved billings, all as more fully described in the attached Exhibit A.

V. The planning of health care facilities as described in Section 24 of the 1971 Hospital Agreement shall be modified to incorporate the changes required by Section 1122 of the Social Security Act (42 U.S.C. Chap. 7).

Exhibit 20

Section 24.1 of the 1971 Hospital Agreement shall be updated as suggested by the 1972 Amendments to the Social Security Act to provide for review of any capital replacement or expansion involving a sum in excess of $100,000.

The failure of H.E.W. to promulgate regulations which specifically delineate the responsibilities of local area wide planning agencies suggests that it may be necessary to revise Section 24. It is the hope of the parties that prior to execution of the 1973 Interim Hospital Agreement some accord can be reached between the Hospital Survey Committee and the present state-designated Regional Comprehensive Health Planning agency as to responsibilities and financing so that conflicts between the two organizations can be avoided.

VI. A program will be continued or provided which will supply patients with information regarding hospital proced[illegible]s and practices.

Guidelines 39, 41, 42, 44, 45, 48 and 54 as presented by the Pennsylvania Insurance Commissioner should be satisfied by a program which insures that patients are advised of the Provider's facilities, services and practices in a timely fashion. Recognizing that the majority of Providers now provide comprehensive patient booklets, an effort shall be made to require all Providers to develop a comprehensive patient booklet for distribution at admission and questionnaires for circulation to patients regarding their treatment. In this regard, a patient Bill of Rights may be developed for adoption by individual Providers after adaption to their particular institution.

Exhibit 20

VII. Blue Cross shall have the right to review the various estimates of expense contained in the budgets submitted for establishment of interim per diem rates, as well as all data and reports supporting the budgeted costs.

Section 18 of the 1971 Hospital Agreement requires that the Provider annually submit its budget to Blue Cross for review and use in developing interim in-patient per diem rates. In this regard, it is recognized that Blue Cross has the right to question budget data and make reviews to substantiate the claimed budget estimates. To permit area hospitals to realize the economies possible through adoption of new management techniques and ideas, Blue Cross may, at the request of a Provider, supply consultants who shall review various aspects of the hospital's operations with the Provider's management and suggest cost-saving procedures.

VIII. The 1973 Interim Hospital Agreement shall be effective as of July 1, 1973 and continue thereafter until March 31, 1974. The continuation provisions contained in Section 27 of the 1971 Hospital Agreement shall apply following termination except that the ninety day period provided in clause (a) shall be extended to ninety-one days for purposes of the 1973 Interim Hospital Agreement.

This Summary of Principles and including by reference thereto, the 1971 Hospital Agreement, shall constitute the basis for a temporary contractual relationship between the Provider and Blue Cross subject to the submission of a formal written contract for execution by the parties following approval of the Pennsylvania Insurance Department. The formal contract shall by this Agreement be completed and readied by representatives of Blue

Exhibit 20

Cross and the DVHC Negotiating Committee for delivery to the Insurance Department not more than 60 days after the date hereof.

Agreed to and accepted this day of 197 .

BLUE CROSS OF GREATER PHILADELPHIA

By _____
President

_____
Name of Provider

By _____

_____
Title of Signing Officer

During the period from the date the attached Principles is approved and June 30, 1974, Blue Cross and DVHC, on behalf of the undersigned Provider, shall negotiate in an effort to resolve the following open items:

1. Possible implementation of a form of pre-admission review for all elective cases.

2. The positions of the respective parties with regard to the following areas:

a. Construction of new health care facilities and expansions or modifications of existing facilities must be thoroughly reviewed with specific emphasis and study of each project's financial viability.

b. In order to encourage the elimination of excessive standby facilities and services, studies as to the continuing need for such facilities and

Exhibit 20

services will be undertaken by the appropriate areawide planning agency when experienced occupancy is below certain established minimums.

During the period from the date the attached Summary of Principles is approved and June 30, 1974, the parties hereto agree to actively support, and to solicit others such as labor, Greater Philadelphia Chamber of Commerce, Greater Philadelphia Movement, to support, efforts to develop through all levels of government programs designed to resolve the problems of hospitals resulting from unreimbursed hospital services as a part of their community service.

BLUE CROSS OF GREATER PHILADELPHIA

By _____

By _____

DELAWARE VALLEY HOSPITAL COUNCIL

By _____

Agreed to and accepted this day of 1974.

_____
Name of Provider

By _____

_____
Title of Signing Officer

Exhibit 20

EXHIBIT A

Proposal for Current Reimbursement Policy to Provide Interim Payments to Providers in the Most Expeditious Manner Administratively Feasible

The basic premise upon which this current reimbursement policy is based is for payment to be constructively received by the Provider as promptly as possible following the patient's discharge.

Based also upon a further premise of the reasonable expectation that the Provider will promptly complete and submit subscribers' bills within seven days after discharge, and Blue Cross shall process bills within six days after receipt, plus an allowance of two days for mail deliveries, or a total of fifteen days, Blue Cross proposes to implement the following payment policy program:

1. The amount of payment for current inpatient subscriber discharges will be determined by the projected number of subscriber discharges during an average fifteen day period multiplied by the projected average Blue Cross allowable cost per case, predicated on budgeted data approved by Blue Cross.

2. The amount of payment for current outpatient subscriber services shall be calculated on the Provider's average calendar day experience of payments by Blue Cross for such services in the most recent available fiscal year, multiplied by fifteen days.

3. The amount of payment for current maternity, nursery and 65-Special indemnity services shall be calculated on the Provider's average calendar day experience of payments by Blue Cross for such services in the most recent available fiscal year, multiplied by fifteen days.

Exhibit 20

4. In the event that the Provider is unable to complete its billing procedure in the time requirement that will provide payment within the fifteen day cycle, the Provider may, at any time request, subject to the approval of the Blue Cross, an additional supplementary payment in an amount equal to the amount provided in Items 1, 2 and 3 above.

5. The supplementary amount will be subject to a payment by the Provider to Blue Cross for interest at a rate of one and one quarter percent above the prime rate of interest charged by The First Pennsylvania Company. Interest to be calculated monthly by Blue Cross with the amount of interest payable deducted from the succeeding remittances. Such interest shall be considered in the same category as any other interest paid for working capital borrowing as an allowable cost.

6. The supplementary payments shall be repaid by the Provider to Blue Cross on mutually acceptable terms, but in no event shall any amount of supplementary payment remain outstanding beyond the date of termination of this agreement.

7. The basis upon which the original calculation was based will be reviewed in conjunction with the receipt from the Provider of current data, e.g. Financial, Statistical, Budget Revisions, etc. for possible revision to assure adequacy of the current payments provided.

8. In the event that any of the advances currently outstanding exceed the amounts available under this agreement, Blue Cross will deduct the over-payment from the subsequent remittances in a pro-rata amount to assure repayment within ninety days, after receipt of notice by Blue Cross.

Exhibit 20

9. To facilitate cash flow to Providers, Blue Cross shall adopt procedures for the processing and paying of approved subscribers' bills received on a *daily* working basis, with detailed remittance listings.

10. Blue Cross agrees to implement the above current reimbursement policy as soon as administratively feasible following member hospitals' ratification of the agreements in principal arrived at during negotiations with DVHC Committee for a new Blue Cross Hospital Agreement.

11. Blue Cross shall submit, upon request, any and all data to Providers necessary to complete the calculations required for the determination of the allowable amounts hereunder.

ADDENDUM No. 1

Any Provider desiring to participate in the following optional program may so elect by executing this Addendum No. 1 to this Summary of Principles.

During the period of the 1973 Interim Hospital Agreement, Blue Cross will establish and finance Experimental Programs in order to give Providers a new impetus in their efforts to develop an innovative and efficient health care delivery system which meets the medical needs of the communities they serve. The detailed methodology to be utilized in designating and implementing these Programs is set forth in the attached Exhibit.

Exhibit 20

Agreed to and accepted this day of 197 .

BLUE CROSS OF GREATER PHILADELPHIA

By _____
President

_____
Name of Provider

By _____

_____
Title of Signing Officer

EXPERIMENTAL PROGRAMS

In an effort to encourage new studies and the development and implementation of improved procedures and methods designed to ensure quality health care in the most cost effective manner, Blue Cross and the Provider parties to the Summary of Principles Agreement (the "Summary Agreement") have jointly developed the following program:

1. Blue Cross shall establish a special segregated fund equal to $15.00 per Blue Cross inpatient case (excluding 65 special cases) paid to all Providers electing to participate in this program. The sum to be allocated to the fund monthly shall be based on the total Blue Cross payments to eligible Providers during that month. The amounts shall be computed from the effective date of the 1973 Interim Hospital Agreement, with the initial payments to be made within 30 days after the date an eligible Provider executes the Summary Agreement.

2. All Providers that are parties to the Summary Agreement shall be eligible for participation in the program. However, within any single fiscal year, each Pro-

vider shall only be eligible to receive grants equal to or less than 3% of its annual Blue Cross payments.

3. The program shall be administered by a Review Committee composed of seven members of which two shall be appointed by Blue Cross. All eligible Providers, in an election conducted by the Delaware Valley Hospital Council, shall elect two members of the Review Committee, with the other three members consisting of the Executive Director of the Philadelphia Health Management Corporation, and one representative each of the Greater Philadelphia Chamber of Commerce and Greater Philadelphia Movement. Each representative shall have the right to designate an alternate and a majority of the representatives or their alternates shall constitute a quorum for doing business.

The Review Committee shall meet at least quarterly to review applications and make commitments under the program. In conducting this function the Committee shall consider only projects or studies (i) whose results can be evaluated, measured and quantified; and (ii) which have received the endorsement of the Provider in interest and Blue Cross.

Any amounts remaining uncommitted at the end of each calendar quarter, commencing June 30, 1974, after consideration by the Review Committee of all proposals, shall be credited to the subsequent quarterly allocations by Blue Cross with any amounts not expended upon the expiration of the 1973 Interim Hospital Agreement to be returned to the general funds of Blue Cross.

4. Eligible Providers would submit to the Review Committee applications for grants to study specific problems or areas and include the following information.

a. Complete and specific documentation as to the needs of the hospital and local community.

b. A specific proposal for use of grant funds with a complete proposed budget.

c. A schedule for implementation of the proposal, including a schedule over which the funds are to be provided and the total amounts minimally required over the life of the program.

d. An explanation of how the proposal would deal with the needs of the community and hospital.

e. A system for regular reports to the Committee which would document expenditures and benefits. Such reports would be made on no less than quarterly basis and include actual performance evaluations.

5. In selecting appropriate proposals for funding, the following are to be given priority:

a. Projects involving hospitals experiencing the greatest net losses in providing services to satisfy the needs of the local community.

b. Projects which will result in the greatest cost saving to both the individual hospital and the local community.

c. Projects involving joint programs among a number of hospitals.

d. Projects involving improvement in the quality of health care.

6. In evaluating the desirability of a given proposal, the Review Committee should consider the following objectives.

a. The basic objective of the experimental plan or proposal as to achieving affectivity and greatest economies without adversely affecting the quality of services provided.

(i) The experimental plan must be a plan whose precedents could not be tested without some change in the application of the present group improvement provisions.

(ii) Although minor capital expenditures may be incorporated as part of a broader-scale plan, major capital expenditures will not be considered eligible for inclusion.

7. All proposed plans must be given reasonable promise and expectation of achieving the basic objective within a reasonable period of time.

8. Participation in a plan must be voluntary for both Blue Cross and the Provider.

9. Application for establishment of an experimental plan can, in addition to hospitals, also be filed by or for physicians, physician groups, clinics, and other individuals or organizations interested in improving the effectiveness of the delivery of health care services to the community.

10. The quality of care provided to beneficiaries under the experimental plan must be maintained or improved.

11. The size, scope and comprehensiveness of a proposal shall be considered in judging the significance of the proposal.

12. The results of the proposal must be capable of the evaluation and the magnitude of specifics quantifiable. The proposal should include a well-developed statistical model which should clearly explain: (i) the objective to be achieved; (ii) the nature of the evaluation proposed; (iii) the type and detail of data to be collected, including the

sample methods to be employed; (iv) the manner in which quality of care will be measured and the controls to be employed; (v) the overall validity of the experiment.

13. The Review Committee may engage consultants, or other assistants, as it feels necessary to aid in the evaluation of such suggested proposals. The cost of such consultants, as well as any consultants used in studying a given proposal submitted pursuant to this program, shall be paid out of the funds established by Blue Cross under this program.

14. The funds provided under this program may be disbursed by Blue Cross to the consultant, agency performing the project or study approved by the Review Committee. Any funds authorized by the Review Committee to be used as developmental funds shall be disbursed by Blue Cross to the Provider as a developmental grant over a period of time as provided in the consultant's recommendation.

15. Any general or special management study or project which is funded pursuant to Section 14 of the Hospital Agreement shall not be duplicated or funded under the program.

16. The results and distribution of all projects, studies and evaluations undertaken pursuant to this program, may be published for the benefit of all health care Providers, without advising the specific hospital involved.

17. Any sums provided under this program are to be used only as budgeted in the submitted application as approved by the Review Committee. Monies provided under this program are not available for off-setting operating losses.

18. All actions taken by the Review Committee require the affirmative vote of at least four members, pro-

vided, however, if the reviewing consultant or the Review Committee determines that granted funds provided hereby have not been used as approved, such grant may be terminated immediately by a majority vote of the committee. In such a case, the affected Provider would be required to repay any such grant within three months of the date of revocation.

19. Periodic reports of funds authorized shall be rendered to all participating Providers by Blue Cross at least quarterly.

ADDENDUM No. 2

Any Provider desiring to participate in the following optional program may so elect by executing this Addendum No. 2 to this Summary of Principles.

In addition to the basic utilization review program outlined in Principle II, the new agreement shall permit each Provider to elect a "comprehensive utilization review program" similar to the Quality Assurance Program QAP sponsored by the American Hospital Association, which is acceptable to the Provider and Blue Cross, for individual implementation. In such event Blue Cross, in recognition of the significant start-up costs of such a program, would provide developmental financing equal to $10.00 per Blue Cross inpatient case (excluding 65 special cases) in addition to its reimbursement of this allowable cost. Payment of the developmental financing would, of course, be conditioned upon continued adherence to such an acceptable program. Further, a Provider which has implemented an acceptable comprehensive utilization review program shall not retrospectively

be denied reimbursement by Blue Cross for hospitalizations reviewed pursuant to such a program. It is agreed that the question as to whether the Provider's comprehensive utilization review program is being satisfactorily implemented and continued shall be subject to a special review procedure.

A temporary waiver of the requirements of preadmission certification and the review of emergency admissions within twenty-four hours after admission will be granted, retroactive to July 1, 1973, for those hosptials which have implemented QAP, or a similar program except for the foregoing two requirements as of the date of execution of this Addendum No. 2. This temporary waiver is conditioned upon the implementation within 30 days after the execution of this Addendum No. 2 of the aforesaid two requirements by the Provider requesting such waiver.

Agreed to and accepted this day of 197 .

BLUE CROSS OF GREATER PHILADELPHIA

By _____
President

_____
Name of Provider

By _____

_____
Title of Signing Officer

Exhibit 23

IN THE COURT OF COMMON PLEAS OF
DELAWARE COUNTY, PENNSYLVANIA

No. 9799 of 1974

CROZER-CHESTER, et al

vs.

BLUE CROSS OF GREATER PHILADELPHIA

Media, Pa., September 25, 1974

AGREEMENT

Before: HON. HOWARD F. REED, JR., J.

APPEARANCES: FRANK H. ABBOTT, ESQ.,
I. HARRY CHECCHIO, ESQ.,
CHARLES C. HILEMAN III, ESQ.,
BRENDA C. KINNEY, ESQ.,
JOSEPH T. LABRUM, JR., ESQ.,
For the Plaintiffs;

DENIS V. BRENAN, ESQ.,
MURRAY S. ECKELL, ESQ.,
DAVID S. MARKSON, ESQ.,
MARC J. SONNENFELD, ESQ.,
For the Defendant.

Exhibit 23

AGREEMENT

1. During the runout period Blue Cross will pay the hospitals named in Exhibit 1 attached the interim rates set forth times the number of Blue Cross days less co-pay immediately retroactive to July 1, 1974, provided however that the rates of the following hospitals, Germantown, Holy Redeemer, Jeanes, Northeastern, Paoli, Suburban, Nazareth, Frankford, St. Agnes, West Park, Sacred Heart-Norristown, Montgomery, Chestnut Hill, and Magee, shall be adjusted to reflect any increased costs applicable to food, fuel or utilities (excluding telephone but not the increase resulting directly from any discontinuance of the charitable allowance), which will be allowed as flow-through items.

2. Any difference between the approved budgeted rates and the requested budgeted rates for fiscal 1974-75 will be resolved immediately by representatives of Blue Cross and each hospital. If any differences cannot be resolved within two weeks, it shall be referred to Frank H. Abbott, Esquire, and Allen W. Stewart, Esquire. Any differences between them shall at the request of either be referred to Judge Howard F. Reed, Jr., who shall have full authority to set the budget rate.

3. In accordance with the procedures heretofore applied in adjusting interim rates for hospitals as of March 31, 1974, Blue Cross shall make appropriate increases in the current interim rates if indicated, based upon the nine-month operating statement and statistical report as of March 31, 1974, retroactive to July 1, 1973, for those hospitals which have not submitted their third quarter report or whose third quarter reports were not considered due to late filing. These hospitals agree to submit accurate reports, and any dispute with respect to such reports shall be resolved in accordance with Paragraph 2 above.

Exhibit 23

4. In accordance with the provisions of the July 1, 1971 Agreement as later modified, but without regard to the July 1, 1972 Amendment, Blue Cross will pay full reasonable costs at the end of and for the runout period.

5. The runout period herein referred to shall be August 16, 1974, to and including August 15, 1975.

6. This Court will retain jurisdiction.

7. The parties agree that negotiations will continue in good faith toward the consummation of a new hospital agreement.

8. This agreement is a final settlement of this lawsuit only and relates only to the runout period and is without prejudice to any other rights of the parties, and shall not be used by plaintiff hospitals to attempt to adversely affect the negotiations of Blue Cross with any other hospital.

EXHIBIT I

Hospital	*Rate*
Crozer-Chester	$139.23
Fitzgerald-Mercy	$109.44* **
Misericordia	$109.44* **
Riddle Memorial	$107.29
Sacred Heart General	$109.56
Taylor	$102.67
Abington	$103.42
Bryn Mawr	$130.22
Episcopal	$140.75*
Germantown	$105.69
Holy Redeemer	$100.69

* These hospitals are entitled to consideration under Paragraph 3 of the Agreement.

** These hospitals are granted the privilege of submitting a new budget.

Exhibit 23

Hospital	*Rate*
Jeanes	$ 88.40*
Lankenau	$137.84*
Methodist	$121.08
Northeastern	$111.41
Paoli	$113.16
St. Joseph's	$ 95.95*
Memorial Roxborough	$104.08
Suburban General	$104.02*
JFK Philadelphia	$ 91.63*
Nazareth	$ 90.86
Frankford	$119.87
St. Agnes	$128.06*
Metropolitan	$132.17
West Park	$111.70*
Sacred Heart-Norristown	$ 86.06*
Montgomery	$ 95.89*
Chestnut Hill	$122.70
Presbyterian	$137.96*
Magee	$117.83

* These hospitals are entitled to consideration under Paragraph 3 of the Agreement.

** These hospitals are granted the privilege of submitting a new budget.

It is further understood as an addendum to this Exhibit 1, that any hospitals which have submitted cost reports as of this time are not entitled to submit another such report.

Exhibit 24

STATEMENT OF THE MEDICAL SCHOOL HOSPITALS OF PHILADELPHIA

TO THE DELAWARE VALLEY HOSPITAL COUNCIL

August 14, 1974

Over the past months, The Delaware Valley Hospital Council and Blue Cross of Greater Philadelphia have been engaged in negotiations in an attempt to develop a new contract between Blue Cross and the hospitals of the Greater Delaware Valley. Through the course of these negotiations certain issues have arisen which have created an impasse to an agreement between The Delaware Valley Hospital Council and Blue Cross, and have given the appearance of the existence of animosity between the hospitals and Blue Cross.

The Medical School Hospitals of Philadelphia—mindful of their responsibilities to their patients, their medical staffs, and the community—believe that the time has come to set forth clearly their position regarding these issues so that the Delaware Valley Hospital Council, other hospitals in the Delaware Valley, the public, and Blue Cross may be aware of a philosophy which differs in some respects from the public posture of the Delaware Valley Hospital Council. We undertake to make this statement with deep consideration of the desirability of maintaining a common "hospital" position in negotiating with Blue Cross. However, the intensity of the feeling about certain basic philosophical differences between Blue Cross and the hospitals is so great that we believe it necessary to formally express our beliefs and our position with respect to the negotiation of a new contract with Blue Cross.

The tenor of the negotiations and the public pronouncements of many parties participating in the negotiations have been characterized by a hostility and animosity that we believe to be inappropriate for organizations dedicated to effective health care delivery. The Medical School Hospitals believe that the relationship between the hospitals and Blue Cross should be business-like and professional but should also be characterized by a cooperative attitude of mutual support to benefit the welfare of our patients. We do not view Blue Cross as an adversary but as a participant in the health care delivery system.

Exhibit 24

A major unresolved issue in the negotiation for a new contract has been the proper role of Blue Cross in assisting the hospitals in their responsibility for cost containment. This problem has focussed on the imposition by Blue Cross of ceilings on increases in cost, which are regarded by many as arbitrary. The Medical School Hospitals believe that it is appropriate for Blue Cross to have an interest in the levels of cost incurred by hospitals in the provision of services to Blue Cross subscribers. Such provisions, if included in a Blue Cross contract, should be reasonable in the light of existing economic conditions, equitable to all providers, should provide for specific and identified circumstances under which the limitations would be waived or adjusted, and should provide a mechanism under which disputes would be equitably and expeditiously resolved. We believe that an attempt should be made to pursue negotiations with Blue Cross to embody these principles in a new contract and in the settlements related to the existing contract.

On a number of occasions various contract offers have been rejected by both Blue Cross and The Delaware Valley Hospital Council. In many of the cases representatives of the Medical School Hospitals have joined in those votes of rejection of Blue Cross offers in the belief that the offers were not adequate, equitable, appropriately

Exhibit 24

detailed, or otherwise sufficient to merit a vote of approval. However, the Medical School Hospitals believe that it is in the best interest of our patients and our institutions to continue our contractual relationship with Blue Cross. Therefore, we urge the Delaware Valley Hospital Council to continue its negotiations with Blue Cross within the spirit of the principles outlined in this statement, and to take such steps as necessary to insure coverage for Blue Cross patients within our hospitals. If the Delaware Valley Hospital Council determines that such negotiation and continued contractual relationship can no longer be pursued under its auspices, the Medical School Hospitals will withdraw their grant of authority to the Delaware Valley Hospital Council to negotiate on their behalf and will seek to enter into negotiations directly with Blue Cross. In this event we will welcome other hospitals who share a community of interest with us in our negotiations with Blue Cross.

We understand the seriousness of the actions that we propose, but we also are mindful of the seriousness of the conditions and circumstances which give rise to our plan of action and assure all interested persons that we undertake this course of action only after careful and serious deliberation and in consideration of our community obligations.

F.H. Barth Pavilion of the Philadelphia College of Osteopathic Medicine

Hospital of the University of Pennsylvania

Temple University Hospital

The Graduate Hospital of the University of Pennsylvania

The Hahnemann Medical College and Hospital of Philadelphia

The Hospital of the Medical College of Pennsylvania

Thomas Jefferson University Hospital

Exhibit 25

MEMORANDUM OF AGREEMENT

Representatives of Blue Cross of Greater Philadelphia (the "Plan") and an Ad Hoc Hospital Committee representing numerous area hospitals have jointly developed the basis for a new Hospital Agreement. While drafts of the specific contract language have not yet been finalized, the parties have reached an understanding in principle and agree that the Hospital Agreement, dated July 1, 1971, as revised by the 1973 Summary of Principles and the Addenda thereto, shall constitute the basis for a new contract after appropriate modification for the following jointly negotiated matters:

1. The Agreement shall be effective as of July 1, 1974 and continue thereafter on a year-to-year basis for a five year term, subject to annual review by the Joint Provider-Plan Committee. The Agreement shall include appropriate provision for amendments and reopening, if indicated by major changes significantly affecting the health care delivery system or in the event of new federal, state or municipal actions, such as National Health Insurance, which would significantly affect the existing arrangements between the parties.

2. A Joint Provider-Plan Committee designed to promote greater understanding and enhance the working relationships between the parties will be established. The specific composition of this Committee as well as its responsibilities, duties and procedures are detailed in the attached Annex A.

3. The Providers will establish a Standing Peer Review Board composed of 12 Provider and 6 public members which shall informally review individual Provider-Plan disagreements, if any. The detailed procedures,

method of appointment and scope of inquiry assigned this Board are detailed in the attached Annex B.

4. The maximum permissible percentage increase in the rate of reimbursement to be paid each Provider shall be established annually, both with respect to interim rates and final payments. This permissible increase shall be 125% of the median percentage increase after allowance for certain adjustments and flow through items. The maximum permissible increase in interim rates shall be computed on a per diem basis, but its application to final payments may be on an inpatient per diem or per case basis, or a total overall cost basis, as retrospectively elected by the Provider. The specific methodology which will be employed in making the foregoing calculation is set forth in the attached Annex C.

5. The Plan shall not reimburse a Provider for educational costs applicable to interns and residents in excess of that annual percentage increase determined as in paragraph 4; provided, however, that this limitation shall apply only if Provider's cost for this line item exceeds a base cost of $5.00 per inpatient day for fiscal 1974-1975 and $5.00 plus the foregoing percentage increase in the prior fiscal year's base for each fiscal year thereafter. At the request of Provider this limitation will be reviewed, and may be modified by the Plan to reflect extraordinary fiscal year fluctuations attributable to the availability of interns and residents or intensified or expanded medical services, when such are adequately substantiated by Provider.

6. A hospital index computed as described in Exhibit F to Annex C will be used to measure price changes during each fiscal year under this Agreement. If the index experiences a percentage change which exceeds the median rate of increase developed as in paragraph 4 above, the

maximum permissible percentage increase in the rate of reimbursement will be recomputed by multiplying the percentage change in the index during the fiscal period by 125% and adding one-half of one percent thereto to reflect intensity factors which may not have been reflected in the approved budgets. In the event the index declines in a subsequent quarter during the fiscal year the maximum permissible percentage increase will be adjusted accordingly so that at the end of fiscal year the maximum permissible percentage increase will be determined using the greater of the median rate of increase or the actual annual change in the index during the fiscal year.

7. As an incentive for all hospitals to exert continuing cost containment measures, the parties have agreed that if a particular Provider exceeds the maximum permissible percentage increase in the rate of reimbursement in any fiscal year but within three years thereafter experiences a percentile increase in inpatient costs over the prior fiscal year, computed as in paragraph 4, which is less than the median percentile increase, the Plan will reimburse the Provider those previously disallowed costs to the extent that the difference in the subsequent fiscal year's percentage increases, as compared with the maximum percentage increase permissible in that year, times that year's inpatient Plan cost, is less than or equal to such unreimbursed amount, as more fully described in Annex C.

8. The parties will review and may amend, when and as appropriate, those sections of the 1971 Hospital Agreement, as modified by the 1973 Summary of Principles, which provide for review by the Hospital Survey Committee in order to recognize any acceptable compact or agreement between the Hospital Survey Committee and the Regional Comprehensive Health Planning Agency, or their successors.

Exhibit 25

9. The parties understand that the Plan may offer the proposed Agreement to other hospitals in the area, but that the Plan warrants and represents that in the event another form of contract is offered generally to short-term acute voluntary non-profit Pennsylvania hospitals, its provisions will be designed to maintain reasonable parity with this Agreement.

10. The Experimental Program option which is included as an addendum to the 1973 Summary of Principles shall be part of the Agreement with the allowance per Plan inpatient case established at $10.00. This accrual will be initiated by the Plan for all Providers executing this Agreement as of the first day of the calendar month next following the date this Agreement is approved by the Pennsylvania Insurance Department. The Joint Provider-Plan Committee shall serve as the Review Committee for purposes of approving eligible programs.

11. Any hospital having a short-procedure unit which has been approved by the Plan may elect to be reimbursed for services rendered by such unit under any of the three options permitted by subsection 2.4.2 of Exhibit A to the 1971 Hospital Agreement, which election shall be separate and apart from its election as to reimbursement for outpatient services. Attached as Annex D is a list of those guidelines to be utilized in establishing and qualifying a short procedure unit.

12. The unrestricted grant to be paid all hospitals qualifying for such amounts under the Optional Utilization Review Program that was added by the 1973 Summary of Principles shall be continued and raised to $12.50 per inpatient Plan case commencing with the effective date of this Agreement (excluding those cases paid under the Medicare supplemental coverage). Furthermore, as of the first day of the calendar month next following the date this Agreement is approved by the Pennsylvania Insurance Department, the Plan will commence making additional grants to qualified Providers to encourage and

Exhibit 25

assist in the development of an effective outpatient utilization review program. The amount of such grants shall be calculated on the basis that two short procedure unit cases equals one inpatient case and five emergency room cases equals one inpatient case. Within six months after initiation of these outpatient grants, each qualifying Provider shall submit to the Plan a report detailing the program of outpatient utilization review (which program shall include provision for peer review) that the Provider has implemented. If a Provider fails to implement a program of outpatient utilization review with such six month period it shall return to the Plan any grant payments previously received.

The Joint Provider-Plan Committee shall, within nine months after the date of the initiation of outpatient grants, develop specific criteria as to outpatient utilization review. Each Provider shall thereafter have a period of three months following the publication of these criteria to modify, if necessary, its own program of outpatient utilization review so as to conform with these guidelines and as evidence thereof shall submit appropriate reports to the Joint Committee for review and approval. At the end of this three month period only those Providers which have an outpatient utilization review program that has been approved by the Joint Committee shall qualify for outpatient grants.

13. This Agreement will be implemented by the various Providers and the Plan as soon as possible after its approval by the Pennsylvania Insurance Department.

14. Reimbursement to Providers for the fiscal year ended June 30, 1974 will be settled utilizing the same criteria and methodology as set forth in this Agreement although the maximum permissible percentage increase in the rate of reimbursement will be calculated using the

fiscal year 1974 cost data submitted with the fiscal 1975 budget rather than fiscal year 1974 budgeted data as the basis for determining the median increase.

15. The terms of the existing relationship between the Plan and Providers executing this accord will be continued until the Agreement is implemented as provided in paragraph 13.

16. Subsection 21.2 of the 1971 Agreement will be modified to include a requirement that the Appeals Board determine if the Plan as well as the Provider has acted unreasonably in forcing a matter to arbitration.

17. Appropriate changes will be made in the language of the 1971 Hospital Agreement, the 1973 Summary of Principles, and this Agreement as agreed to by counsel for the respective parties, in order to provide greater clarification.

The parties hereto, intending to be legally bound have caused these presents to be executed by the proper officers as of the date set forth below.

Date of Execution:

BLUE CROSS OF GREATER PHILADELPHIA

_____

By: _____

_____

Name of Provider

By: _____

_____

Title of Signing Officer

Annex A

JOINT PROVIDER—PLAN COMMITTEE

In order to realize the objectives set forth in the preamble of the Agreement, promote greater understanding and enhance the working relationships between Providers and the Plan, a Joint Provider—Plan Committee (Joint Committee) shall be established to provide for joint review and evaluation of evolving concepts of mutual interest which may arise during the term of the Agreement.

1. *Composition of Joint Committee*

The Joint Committee shall initially consist of six Provider members constituting the "Provider Committee", and six Plan members constituting the "Plan Committee". The initial organizational meeting of the Joint Committee shall be held within 60 days after this Agreement is implemented.

The Provider members shall be nominated and elected by majority vote of all Providers contracting with the Plan under agreements which include provision for a Joint Provider—Plan Committee, with each such Provider having one vote. Provider members shall represent a cross-section of such Providers and nominations shall reflect the requirement that the Provider Committee at all times include at least one member from a medical school hospital, an other major teaching hospital, a non-teaching hospital, a specialty hospital and a suburban hospital. Of the six Provider members, two shall be initially elected for a period of one year, two for a period of two years, and two for a period of three years; thereafter, members shall be elected for a period of three years. Mr. Charles Paxson, with the aid and assistance of

the other members of the Ad Hoc Hospital Committee, shall take appropriate action to ensure that the initial election of the Provider Committee is completed within sixty days after this Agreement is approved by the Pennsylvania Insurance Department.

The Plan Committee membership shall be appointed by the Plan with two members being initially appointed for a period of one year, two for a period of two years, and two for a period of three years; thereafter, members shall be appointed for a period of three years.

The Provider and Plan Committees shall each elect a chairman from its membership at the time of Joint Committee's annual meeting. In odd-numbered calendar years the Chairman of the Provider Committee shall be the Chairman of the Joint Committee and in even-numbered calendar years the Chairman of the Plan Committee shall be Chairman of the Joint Committee.

The Chairman of the Provider Committee shall, at least semi-annually, submit a report to the Plan's Executive Committee with regard to matters considered by the Joint Committee, and if requested by the Plan's Executive Committee, attend a meeting of the Plan's Board of Directors to discuss the aforesaid reports.

The Joint Committee may be expanded beyond the originally designated number by the mutual agreement of the Provider and Plan members.

2. *Meetings of the Joint Committee*

The Joint Committee shall hold its annual review meeting in December of each year beginning with 1975 for the purpose of evaluating this Agreement and its impact on the parties. The Joint Committee shall hold regular quarterly meetings, in order to carry out its functions as hereinafter delineated. Additionally, special meetings shall be called by the Chairman within 15 days

upon receipt of a written request of any four members to the Chairman. At all such meetings a quorum shall consist of not less than three Provider and three Plan members.

3. *Procedures of the Joint Committee*

3.1 The Joint Committee shall at its first meeting, establish a general organizational structure and operating procedures to be used in carrying out its various functions. Nothing therein, however, shall preclude the Joint Committee from inviting individuals and organizations having special expertise to participate and present data regarding the various areas under discussion; or from forming sub-committees to study particular subjects as the Joint Committee sees fit; or from other approaches which the Joint Committee may deem appropriate to provide necessary assistance to the Joint Committee. In this connection, the Provider and the Plan agree to cooperate fully with the Joint Committee and provide it with such data consistent with disclosure policies, as may from time to time be requested.

3.2 The Joint Committee shall have a written agenda for all meetings and such will be sent to each member at least five days prior to all scheduled meetings.

3.3 Recommendations of the Joint Committee shall be made only by joint agreement reflecting concurrence of a majority of Provider members and a majority of the Plan members present and shall be transmitted to the Providers and to the Plan for appropriate consideration by their governing bodies.

4. *Additional Duties and Responsibilities of the Joint Committee*

4.1 The Joint Committee shall be responsible for verifying the calculations made by the Plan as to the

median and maximum permissible percentage increases in costs, and the Provider by executing this Agreement agrees that such information, which shall be treated as confidential and privileged by the Joint Committee, may be released by the Plan for this limited purpose.

4.2 Within nine month after the date the Plan commences payment of grants for outpatient utilization review the Joint Committee shall develop written criteria for use by Providers in creating an effective out-patient utilization review program. Thereafter, the Joint Committee shall review and approve, as appropriate, individual Provider plans, which when implemented, would qualify for grant payments by the Plan.

4.3 All applications by Providers seeking funding for Experimental Programs, must be submitted to the Joint Committee for review and approval based on the criteria set forth in the 1973 Summary of Principles.

4.4 The Joint Committee shall review the guidelines for Short Procedure Units which are attached as Annex D and may from time to time recommend changes to those guidelines.

Annex B

STANDING PEER REVIEW BOARD

1. *Function*

In the event of any disagreement between an individual Provider and the Plan that cannot be resolved by informal conference between them, the disagreement shall first be referred in writing to a Standing Peer Review Board for review and recommendation.

2. *Composition of the Peer Review Board*

The Board shall consist of 12 members elected by a majority vote of all Providers contracting with the Plan under agreements including this provision, and six public members of which three will be designated by the Greater Philadelphia Chamber of Commerce, and three by the Greater Philadelphia Movement from among their respective memberships. Provider members shall represent a cross-section of all hospitals contracting under agreements providing for a Peer Review Board and nominations shall reflect the requirement that the Board at all times include at least one member from a medical school hospital, an other major teaching hospital, a non-teaching hospital, a specialty hospital and a suburban hospital. No person shall be designated a public member who is a member of the governing body or an employee of any health care provider in the Greater Delaware Valley area or the Plan. Initially, one third of the Board shall be elected or appointed for a period of one year, a third for two years and a third for three years. Thereafter, individuals elected or appointed to the Boa. will serve for three-year terms, and may serve no more than two consecutive terms. Mr. Charles Paxson, with the aid and assistance of the Ad Hoc Hospital Committee, shall take appropriate action to ensure the Board is elected and holds its initial organizational meeting within sixty days after this Agreement is implemented.

The Board shall elect a Chairman and a Vice Chairman at its initial organizational meeting who shall serve in the absence of Chairman.

3. *Designation of Peer Review Panels*

Whenever the Board receives a written request to recommend a solution to a disagreement, the Chairman,

within ten days after receipt thereof having determined that informal conferences have failed to resolve the differences, shall designate a Peer Review Panel of five Board members of which three shall be Provider representatives, one of whom shall be designated as Chairman by the Chairman of the Panel, and the remaining two shall be public members.

4. *Peer Review Panel Procedures*

The Peer Review Panel will conduct informal hearings with regard to those matters referred to it by the Chairman of the Board within 15 days from the date of the Panel's appointment at which hearings both parties will appear, present testimony and respond to questions. A recommendation signed by a majority of the Panel shall be made within 15 days of the hearing and submitted in writing to the parties and the members of the Board.

5. *Board Review*

Upon the written request of six Board members, filed within ten days after receipt of a Panel's written recommendation, the Board will meet to review the Panel's action. Any such meeting shall be held within 30 days after receipt of the Panel's recommendation. The results of any Board review concurring with or modifying the Panel's recommendation shall be submitted to both parties within 15 days after the meeting. The parties to this Agreement understand and agree that the recommendations entered by either a Peer Review Panel or the Peer Review Board are only advisory and shall not bind the parties unless they otherwise agree.

6. *Restriction on Subsequent Action*

The Plan and Provider agree that no action at law or in equity or arbitration in connection with the application, operation or interpretation of this Agreement shall be initiated by either party until it has first exhaused the review procedure hereinabove described and in the event any such action is thereafter commenced, the parties agree and stipulate that the recommendations of the Panel or Board and the record or transcript made before the Panel or Board shall not be offered into evidence; and further, it is agreed and stipulated that neither the Chairman nor any individual member of any Panel or of the Board, or the staff thereof, shall be called to testify before such court or arbitration board as to any matter with regard to any dispute presented to any Panel or to the Board.

7. *Staffing*

The Plan shall provide permanent staff for the Board and its Panels at such time and in such number as may reasonably be requested by the Chairman of the Board.

8. *Confidentiality*

All matters presented to the Board or any Panel shall be treated as confidential and privileged.

9. *Annual Meeting*

The Board shall hold an annual meeting, at which the Chairman will present a report of the activities of the Board and its Panels, and at which time the Board shall consider recommendations for changes in procedure. Elections will also take place at this meeting.

Exhibit 25

Annex C

18.4 *Calculation of Reimbursement.*

The reimbursement to be paid the Provider by the Plan under this Agreement as either an interim payment or pursuant to the settlement procedures detailed in Exhibit A hereto shall be subject to the following:

18.4.1. Subject to the requirements of this Section 18 and subsections 1.4 and 2.4.6 of Exhibit A, Part I, the Provider's permissible rate of increase in costs for any fiscal year shall not exceed the total allowable costs approved by the Plan for the previous fiscal year, plus such increase as may be permitted by subsection 18.4.2. hereof.

18.4.2. Upon receipt of budgets from those non-profit hospitals contracting with the Plan under accords requiring that budgets similar to those described in Exhibit B be submitted and reviewed, the Plan shall determine each Provider's percentile change in its budgeted inpatient per diem costs as compared to the prior fiscal year's allowable inpatient per diem costs, after adjusting both in accordance with subsection 18.4.3. After this percentage change for each such Provider has been calculated, the Plan shall compute the median percentage change for the group as a whole and submit this data to the Joint Provider-Plan Committee for its confidential review and verification, which limited release of information the Provider hereby authorizes. The rate so calculated and verified shall then be multiplied by 125% to establish the maximum permissible percentage increase in inpatient per diem costs for the budgeted fiscal year over the prior fiscal year, subject to those adjustments required by subsection 18.4.3. Similarly, the percentage increase for the budgeted fiscal year applicable to each Provider shall be calculated on both an inpatient per case and total cost

Exhibit 25

basis to determine a median rate of change for the group on each such basis. These rates will then be multiplied by 125% to compute the maximum permissible rate of increase on both an inpatient per case and total cost basis.

18.4.2.1. The initial maximum permissible percentage increase in inpatient per diem rates as described in 18.4.2 shall be calculated by the Plan based upon those budgets received and processed prior to the beginning of each budgeted fiscal year. This initial percentile change shall then be used in fixing the initial inpatient interim per diem rates. Thereafter, the Plan shall again calculate this initial percentile change, prior to each October 31, based upon budgets received and approved on or before September 30, to determine an adjusted percentage change. Finally, on or before January 15 in each fiscal year, the Plan shall recompute the adjusted percentage change based on the prior fiscal year's cost reports that were conditionally approved by the Plan at desk audits completed prior to December 31.

18.4.2.2 On or about the first day of each July, August and September, the Plan will notify the Peer Review Committee of those Providers which have not submitted budgets. No change in a Provider's interim per diem rate shall be made by the Plan for a new fiscal year until such time as the Provider's budget has been submitted to and approved by the Plan.

18.4.2.3. As soon as each Provider's final cost reports for the budgeted fiscal year are conditionally approved by the Plan at the desk audit, the percentage increase in the Provider's allowable costs for that fiscal year shall be compared with the prior year's allowable costs, both adjusted as described in subsection 18.4.3, to determine the percentage increase in inpatient costs on a per diem or per case basis, or an overall total cost basis. The Plan

shall then submit these figures to the Provider for review. In the event one or more of these percentile changes exceed the maximum permissible percentage increase established by subsection 18.4.2, after any adjustment required by subsection 18.4.4, the Provider shall submit to the Plan its initial written election as to which basis (per case, per diem or total cost) it desires to use for purposes of the limitation described herein. Thereafter, at such time as final audited data for the fiscal year is available, the percentage increase on each basis shall again be computed and submitted to the Provider which, if appropriate, will finalize its election as to the comparative basis it desires be used for purposes of the limitation on reimbursement. Once having made a final election the Provider may not change basis without waiving its right to recover amount previously disallowed pursuant to subsection 18.4.5.

18.4.2.4. The rate permitted the Provider shall be adjusted for unanticipated costs (amounting in the aggregate to more than ten cents ($.10) in the inpatient interim per diem rate), including changes in payments by the Provider made pursuant to Sections 14 and 24 as well as the cost associated with implementing the recommendations of studies made pursuant to Section 14 hereof when such costs (a) are beyond the control of Provider or required by an accrediting body, governmental agency or court order, (b) were not foreseeable at the time the annual budget was submitted to Blue Cross, (c) are adequately demonstrated by appropriate records of the Provider, and (d) the Provider takes timely remedial action to attempt to minimize any such increase in costs. A list of illustrating examples of such unanticipated costs are detailed in Exhibit D hereto.

18.4.3. In calculating the percentage change between the prior and budgeted year's inpatient costs pursuant

to subsection 18.4.2, the following adjustments shall be made: (a) all direct costs associated with the line items identified as food, fuel and utilities (excluding telephone, but not the increase arising directly from the discontinuance of the charitable allowance) in the budget forms attached as Exhibit B shall be excluded, and the increases in such costs shall be paid by the Plan without regard to the foregoing limitations on reimbursement; (b) depreciation and interest on capital items as well as all lease rentals related to real estate or capital equipment shall be excluded; (c) the budgeted interest cost attributable to borrowings for operating funds and working capital shall be recomputed at the end of each fiscal year to determine the difference between the budget and actual cost attributable solely to the variation in budgeted and actual interest rates during the year, which amount is then either added or subtracted from the budgeted cost for purposes of determining the final limitation required by subsection 18.4.2, and (d) appropriate additions or reductions shall be made to reflect medical services or facilities initiated or discontinued by the Provider so as to annualize the two periods for comparison purposes, said procedure being more fully described in Exhibit E hereto.

18.4.4. In the event the annualized percentage change in the "Hospital Cost Index", computed in accordance with the procedure described in Exhibit F hereto, exceeds the median percentile increase for all Providers calculated on either an inpatient per case or per diem basis, or on an overall total cost basis, as indicated in subsection 18.4.2, the appropriate median percentile change shall be increased to the percentage change indicated by the Hospital Cost Index multiplied by 125% plus one-half of one percent to fix a final maximum limitation on approved

inpatient reimbursement. In the event the index declines in a subsequent quarter during the fiscal year the maximum permissible percentage increase will be adjusted accordingly so that at the end of fiscal year the maximum permissible percentage increase will be determined using the greater of the median rate of increase or the actual annual change in the index during the fiscal year.

18.4.5. In the event reimbursement to the Provider is limited in any fiscal year during the term of the Agreement, the Provider may, during the three fiscal years immediately following the fiscal year such limitation applied, be reimbursed for all or a portion of such disallowed cost. In determining what portion, if any, that the Provider may recover in any year during the three year period, the Provider's actual allowable costs for each such year, on the basis selected in subsection 18.4.2, will be compared with the prior year's actual allowable cost to determine the annual percentage increase in cost, after making the adjustments required by subsection 18.4.2. If this increase in any year during the three year period is less than the median permissible increase for such year (computed in accordance with subsection 18.4.2.2), the Provider will be allowed a credit for said year (adjusted as provided in subsection 18.4.3) not to exceed the previously disallowed cost. This credit, which shall be equal to the product of (i) the percentile difference between the Provider's actual increase and the maximum permissible increase allowed all Providers in such year, and (ii) the Provider's total allowable inpatient costs, will be reimbursed to the Provider, without interest, by the Plan in the year or years earned. In the event this Agreement should terminate prior to the expiration of the three year period wherein recovery of a previous disallowance may be effected by the Provider,

any new contract or agreement between the Plan and Provider applicable during such three year period shall incorporate this subsection 18.4.5 by reference.

18.4.6. The initial percentage limitation required by subsection 18.4 shall be computed to the nearest one (0.01) hundredth of a percent but subsequent adjustments shall only be made in the event there is a change of more than one (0.1) tenth of a percent.

Exhibit D

Unanticipated Costs

The following is a list of those items which would generally be considered as an unanticipated cost for purposes of subsection 18.4.2.4 and thus require revision in the inpatient rate:

1. Imposition of real estate or other tax levies not currently projected or presently in effect. This would mean that if real estate taxes were assessed against non-profit hospitals such would require adjustment although the increase in F.I.C.A. taxes would not since they are already known changes which will affect all hospitals and be reflected in the median increase.

2. Unforeseen changes in Federal, state or local statutes, administrative or judicial decisions or regulations which adversely affect expenses, such as pension plan insurance, new pension vesting requirements, environmental or safety standards.

3. Natural catastrophes, civil insurrection or other occurrence, resulting in substantial physical damage to the hospital's physical plant which adversely affects traditional patterns of patient care.

4. Prolonged failure of major equipment which has a material effect on the hospital's ability to provide its customary and historical patient services.

5. Identifiable expenditures required in order to maintain accreditation due to changes in the accrediting body's standards.

The following list is illustrative of the type of occurrences which would *not* qualify for exception under Subsection 18.4.2.4 contemplated above:

1. Low occupancy or underutilization of a department, facility or service.

2. Underutilization of supportive or ancillary services.

3. Failure to comply with planning agency recommendations pursuant to Section 24 in a timely manner.

4. Maintenance of excessive facilities or staffing levels resulting in abnormal capital or wage costs.

EXHIBIT E

Annualization Adjustments

Subsection 18.4.3 requires that in determining the percentage cost increase that a Provider experiences in a given fiscal year over a prior year, appropriate adjustments will be made in the base year to reflect changes in services or facilities so as to normalize the two periods for purposes of making the calculation. For example, any change in the Provider's services or facilities which requires the approval of the Hospital Survey Committee, Inc. (HSC), as detailed in Section 24 of the 1971 Hospital Agreement and modified by the 1973 Summary of

Principles, must be identified separately in the Provider's budget and adjustment therefor made in the calculation of the annual percentage increase attributable inpatient costs.

Annualization adjustments will be made employing generally accepted accounting procedures and Medicare guidelines, as appropriate.

EXHIBIT F

Hospital Cost Index

The Hospital Cost Index (HCI) referred to in subsection 18.4.4 will be calculated at the end of each calendar quarter by the Plan, which calculation shall then be verified by the Joint Provider-Plan Committee. To the extent the HCI produces a percentile price change which is greater than the median percentile increase for all Providers (calculated as indicated in subsection 18.4.2) the maximum permissible percentage increase will be increased as provided in subsection 18.4.4.

The HCI is designed to encompass all things that area hospitals purchase except for those items specifically identified in subsection 18.4.3(a) and 18.4.3(b). The HCI measures the price change in each such item as compared with the prior fiscal year to determine an annual rate of increase. The various labor and non-labor cost categories which comprise the HCI are set forth in the following table together with the index which will be used in measuring the change in that cost, as well as the weight, expressed as a percentage that will be attributed to each such category in calculating the HCI.

SOURCES OF WAGES AND PRICE INDEXES

	Labor Categories	*Name of Index*	*Source*	*Weighting (%)*
A	Administration	"Insurance" Wage Rate	#63, Table C-2, *Empl. & Earn.*	
B	Clerical	"Insurance" Wage Rate	#63, Table C-2, *Empl. & Earn.*	
C	Nursing	"Hospitals" Wage Rate	#806, Table C-2, *Empl. & Earn.*	
D	Technical	"Services" Wage Rate	Table C-2, *Empl. & Earn.*	
E	Housekeeping, Kitchen, Aids	"Hotels" Wage Rate	#702, Table C-2, *Empl. & Earn.*	
F	Professional	"Hospitals" Wage Rate	#806, Table C-2, *Empl. & Earn.*	
G	Skilled	"Services" Wage Rate	Table C-2, *Empl. & Earn.*	
	Non-Labor Categories			
H	Medical & Surgical Equipment & Disposables	(.2)-Misc. Rubber Products	#07-13, WPI, *Monthly Labor Review*	
		+(.7)-Unsupported Plastic Film & Sheeting	#07-22, WPI, *Monthly Labor Review*	
I	Drugs	Drugs and Pharmaceuticals	#06-3, WPI, *Monthly Labor Review*	

	Non-Labor Categories	*Name of Index*	*Source*	*Weighting (%)*
J	Linens and Wearing Apparel	Sheets	CPI, *Monthly Labor Review*	
K	Office Supplies	Paper	#09-13, WPI, *Monthly Labor Review*	
L	Paper & Disposables	Sanitary Paper Products	SJC Code 2647, Table 32, *Monthly Labor Review*	
M	Chemicals	Industrial Chemicals	#06-1, WPI, *Monthly Labor Review*	
N	Kitchen & Housekeeping Supplies	(.5) Laundry, Soap, Detergent	CPI, *Monthly Labor Review*	
		+(.25)-Dinnerware	CPI, *Monthly Labor Review*	
		+(.25)-Flatware	CPI, *Monthly Labor Review*	
O	Maintenance Supplies	+(.5)-Prepared Paints	#06-21, WPI, *Monthly Labor Review*	
		(.5)-Paint Materials	#06-22, WPI, *Monthly Labor Review*	
P	Laundry	Laundry, Flatware	CPI, *Monthly Labor Review*	
Q	Insurance	Property Insurance Premiums	CPI, *Monthly Labor Review*	

Exhibit 25

Annex D

GUIDELINES FOR A SHORT PROCEDURE UNIT

1. The Short Procedure Unit (SPU) is a segregated facility established by a Provider for the performance of therapeutic and diagnostic procedures that (i) cannot safely or appropriately be accomplished on a conventional out-patient basis, (ii) are best done in a hospital setting, and (iii) are usually completed within an eight-hour period without requiring an overnight stay in the hospital. Exceptions to the foregoing eight-hour limit may be made as justified on a case-by-case basis.

2. The procedures to be performed in the SPU are usually those that can be scheduled in advance by the attending physician, but after which the patient cannot be discharged without a limited post-procedure observation period.

Some examples of the procedures which are customarily performed in the SPU are:

Multiple x-ray studies

Endoscopic procedures

D & C's and D & E's

Transfusions

Certain chemotherapeutic procedures

Angiograms

A wide range of minor surgical procedures, especially those requiring general anesthesia and observation of patient for a period of time following the procedure.

3. The volume of procedures necessary to justify a SPU should require a minimum of four designated beds for post-procedure recovery (which may be used for

Exhibit 25

other purposes in the event of insufficient SPU procedures) and an appropriate staffing.

4. The SPU should include professional and administrative control and supervision to assure appropriate utilization so that patients are not admitted who could be appropriately cared for on a conventional out-patient basis.

5. The Plan will provide benefits to Subscribers receiving care in a SPU as if they were inpatients, but reimbursement will be made as if the SPU care were rendered on an out-patient basis.

6. Routine service charges in the SPU may not exceed the hospital daily service charge for the most prevalent semi-private accommodations for one day.

7. Appropriate material shall be developed by the Provider for the information of its medical staff concerning utilization and scheduling as well as brochures for distribution to patients who will be cared for in the unit.

8. The Joint Provider-Plan Committee shall from time to time review the utilization review standards and minimal requirements encompassing the above, which shall be subscribed to by the hospitals as a prerequisite to any grant payments with regard to the SPU.

Exhibit 28

Pennsylvania Act of August 2, 1975 (No. 94)
(appended to Jurisdictional Statement)

Exhibit 29

SCHNADER, HARRISON, SEGAL & LEWIS

(Letterhead)

July 8, 1975

Honorable William A. Shephard
Insurance Commissioner
Insurance Department
Finance Building—Room 108
Harrisburg, PA. 17120

Dear Commissioner Shephard:

At our meeting on July 3, 1975, Governor Shapp asked us to put in writing what we consider to be the remaining issues and to state our position on each of them.

DVHC believes the remaining issues are as follows:

1. *Unreimbursed Patient Care and Operating Growth Need*

We will accept annually 7½% based on the total Blue Cross reimbursable costs of Provider which shall be paid to the Delaware Valley Hospital Council and distributed by it among the Providers.

2. *Areawide Planning of Health Care Facilities*

Provider shall comply with PL 92-603 § 1122 and applicable sections of PL 93-641 when implemented. We do not object to the "B" Agency, or whatever agency is empowered under the law contracting with the Hospital Survey Committee to perform functions required by law. However, only the final decisions made by the planning agency designated by law will be binding on the parties.

3. *Term of Agreement*

We will agree to a firm two (2) year contract terminating on June 30, 1977, with neither party having the

right to terminate the agreement during the two (2) year period. However, we will not agree to any run-out period after June 30, 1977.

4. *Retroactivity*

We believe that any agreement has to be retroactive to July 1, 1974.

During the retroactive period Providers will be reimbursed their total Blue Cross reimbursable costs based generally on the 1971 Agreement as modified by the 1973 Agreement of Principles and recent negotiations, and with no ceilings or Medicare cost limitations of any kind.

We would agree to your suggestion to give Blue Cross credit for money paid to Subscribers where Blue Cross has paid non-member benefits on a per diem basis, but if Blue Cross has paid full charges to a patient, we will not give Blue Cross credit for the amount in excess of reimbursable cost. Providers will actively pursue collection procedure against those patients who did not pay Provider the money received from Blue Cross.

We believe that we have reached agreement on the other items. However, we cannot be sure until we attempt to put the other items into contract form.

Sincerely yours,

/s/ FRANK H. ABBOTT

Frank H. Abbott, Attorney
for Delaware Valley
Hospital Council

(As Presented by DVHC Negotiators at Mediation Session with Governor Shapp on August 1, 1975)

ADDENDUM TO DVHC'S PROPOSED AGREEMENT DATED JUNE 10, 1975

The attached proposed agreement was discussed with Blue Cross and the Insurance Department on June 12, 1975. The Hospitals resubmit the proposed agreement subject to the following changes:

Section 3. Utilization Review. Each Provider will continue to use its present UR method as long as Blue Cross uses its present enforcement procedure until the new Medicare regulations are implemented.

Section 5.3.2 and 5.3.3 of the 1971 agreement would be reinserted since some Providers do have wards.

The first paragraph of Section 7 of the 1971 agreement shall be reinserted.

Section 20—Appeals Procedure—Abbott and Stewart shall agree upon a general appeals procedure which shall provide for immediate judicial proceedings unless the parties immediately select an arbitrator or arbitration board to hear the dispute and render a binding decision.

Section 21—Term of Agreement shall be from July 1, 1975 to and including June 30, 1977 with neither party having the right to terminate the agreement during the two (2) year period. There shall be no run-out period after June 30, 1977.

The agreement would be retroactive to July 1, 1974. During the retroactive period Providers will be reimbursed their total Blue Cross reimbursable costs based on the 1971 agreement as modified by the 1973 Agreement of Principles, the Media Court settlement and recent negotiations with no ceilings or Medicare cost limitations of any kind. Providers would agree to give Blue Cross credit for money paid to Subscribers where Blue Cross has paid non-member benefits on a per diem basis, but if

Exhibit 29

Blue Cross has paid full charges to a patient, Providers will not give Blue Cross credit for the amount in excess of the Blue Cross reimbursable cost. Providers will actively pursue collection procedure against those patients who did not pay Provider the money received from Blue Cross. Blue Cross will provide Provider with a list of all Subscribers and their dependents who received Covered Services indicating the amount of money paid to the Subscriber or the dependent and if the Subscriber has not paid Provider, Blue Cross will notify each such Subscriber that they are expected to make such payment.

Blue Cross will identify total non-contract inpatient days of service multiplied by the current per diem rate, deduct from it the total dollars paid by Blue Cross to the Subscribers and pay the balance to the Provider within thirty (30) days from the execution of an agreement as an interim payment to be adjusted on final audit.

Exhibit "A" attached to the Provider's proposed agreement shall be deleted and in lieu thereof, Providers will be reimbursed their total Blue Cross reimbursable cost based on the 1971 Agreement as modified by the 1973 Agreement of Principles, the Media Court Settlement and recent negotiations with no ceilings or Medicare cost limitations of any kind. In addition, Blue Cross will pay quarterly an agreed upon percentage based on the total Blue Cross reimbursable cost of each Provider as determined herein, to the Delaware Valley Hospital Council and distributed by DVHC among the Providers as determined solely by the Delaware Valley Hospital Council.

During the term of the agreement the Government shall sponsor and pay for a commission to study the DVHC proposed formula or method of reimbursement as set forth in our original Exhibit "A".

Exhibit "B" shall remain as proposed, except that the appeals procedure in the event the RRC members can-

Exhibit 29

not agree on a majority decision as to the establishment of the interim rate, the matter shall be referred to the Insurance Commissioner who shall decide which of the two suggested interim rates shall apply. Until the Insurance Commissioner decides, the rate established by the DVHC representatives shall be paid by Blue Cross. If either party disagrees with the Insurance Commissioner's decision, it shall have the right to appeal that decision through the Appeals Procedure.

Exhibit 30

PROCEDURES UTILIZED IN REVIEW OF BUDGETS AND THE ESTABLISHMENT OF INTERIM RATES

SUBMISSION OF BUDGETS—Providers should submit detailed annual budgets for the purpose of prospectively establishing interim inpatient reimbursement rates for each fiscal year. The budget must be submitted forty-five days prior to the beginning of the provider's fiscal year and have prior approval of the provider's budgetary committee.

BUDGET FORMS—Budgets must be submitted on standard forms which were designed jointly by the hospitals and Blue Cross at the time of the development of the 1971 Hospital Agreement. The forms provide necessary information in sufficient detail for a comprehensive analysis of budgeted costs, toward the establishment of reasonable and accurate interim rates. The information is supplied for a three year period; the most recent year for which complete actual experience is available, the current year consisting of approximately ten months actual and two months projected, and the budget for the subsequent year. Expenses are categorized into four main divisions:

1. Salaries and Wages
2. Supplies and Expense
3. Depreciation
4. Interest of Indebtedness

Each of the main divisions are further refined to provide the detail for analysis.

Salaries and Wages—These expenses are divided into both the individual general service departments such

Exhibit 30

as the administration and overhead, as well as the direct patient care departments such as nursing service and the separate ancillary services. For each of the three years the expense is identified with the applicable number of full time employees and the number of paid hours.

Supplies and Expenses—These expenses are also divided as above. Additionally, expenses of a non-departmental nature are provided such as payroll taxes, insurance, and the separate employee fringe benefits.

Depreciation—The expense is detailed by asset classification and by the method used in computing the depreciation.

Interest—The expense is sub-divided into two categories, as interest related to either capital indebtedness or working capital indebtedness.

The forms also provide the mechanism for the establishment of the interim rate utilizing the detailed expenses. Non-allowable costs that are unrelated to patient care are listed in detail and then deducted from the total expenses. Based on actual experience, the inpatient portion of the expenses are determined and when divided by the inpatient days the inpatient interim rate is established.

In order to provide a comprehensive base for accurate comparisons and review, several supplementary questionnaire forms are required. These include a review of the personnel policies and general subjects as:

1. Participation in professional or general services.
2. Status of Cost Filings with Third Parties.
3. Service Contracts.

4. Detail of Rentals and Leases.

5. New facilities or programs.

6. Hospital based ancillary services which bill separately.

A separate form is required for medical educational expenses including the salaries, fringes, and supplies of the interns, residents, and other related personnel. This is used in computing the contractual limitation of the medical education costs. Lastly, for purposes of statistical comparison, a departmental expense summary with statistical and per diem comparison is required.

BUDGET DESK REVIEW PROCEDURE—The initial step in the review of the budget is a general and mathematical check. This is performed uniformly with established procedure for each budget submitted and includes the following:

1. Verification that all forms have been submitted and are complete.

2. Total expenses for the *actual* fiscal year are traced to the appropriate Medicare and Blue Cross cost reports to guarantee that the budget is prepared consistent with actual experience.

3. All amounts appearing on inter-related schedules are cross referenced to assure that they are reported in a consistent manner.

4. Footing and Cross Footing of all schedules to assure that the mathematics are correct.

5. Mathematical Review of all calculations which require multiplication or division.

This review is performed following a prescribed format. Each step completed in accordance with written instructions is accounted for through a check list to assure the completeness of the review.

PROFESSIONAL REVIEW OF BUDGET—This part of the budget review is considered of greatest importance as it provides the analysis necessary to assure reasonableness and justification of the rate to be established. The procedures are varied, related to all aspects of the budgets, detailed as follows:

1. Utilizing the *actual* fiscal year costs submitted on the budget, a comparison is made to assure that proper non-allowable costs have been accurately eliminated in preparing the budgeted year. Both direct and indirect costs associated with the non-allowable cost centers must be deducted from total expenses. Amounts deducted in the budgeted year should be of the same proportion as the actual year, unless a change in the service has been identified. All revenues including restricted grants that were a reduction of expenses in the actual year should likewise be reflected as reductions in the budgeted year.

2. The final Blue Cross cost report settlement is reviewed to determine the effect of audit adjustments made as a result of the audit by the independent public accounting firm. All audit adjustments of a reoccurring nature should be reflected proportionately in the budgeted year as a reduction of total expenses. In the actual year the percent of audit adjustments to total expenses is computed and then applied to the total budgeted expenses.

3. The percentage used in determining the split of budgeted inpatient and outpatient costs is com-

pared to actual experience. If it is not the same, further review is made to justify the variance, including the statistics related to the change in inpatient days and ancillary utilization and outpatient services.

4. Budgeted inpatient days are reviewed for reasonableness. Any changes from actual experience must be justified. Consideration is made as to the accuracy of previous budgets to determine if there has been a consistent trend in inaccurately forecasting the days.

In addition to the review of total expenses and the resulting interim per diem rate, careful analysis is performed on the expenses as detailed by department to determine any large increases inconsistent with the increase in total expenses. The review is made by each of the four main category of expenses.

1. *Salaries and Wages*—The percentage increase in salaries is calculated for each cost center for the three years submitted on the budgets. Justification is required for any increases above the average. The salary for each full time equivalent employee is also computed and reviewed for reasonableness. Comparison is made to assure that based on previous experience the hospital is not overbudgeting the employees based on approved open positions when in reality the full complement is never attained. Salaries are also reviewed when possible to comparable positions in hospitals in the same local area.

2. *Supplies and Expenses*—Percentage increases are also calculated in the same manner as the above salaries. Increases are reviewed on a total cost basis as well as a per diem basis. Additionally certain department costs are reviewed based on the statistics related to the specific department. For example,

dietary would be reviewed on the cost per meal; operating room on the number of operations; housekeeping on the number of square feet, etc. In every instance, if the analysis reveals items at large variance with the average of that hospital or similar hospitals, justification is required before the costs are recognized.

3. *Depreciation*—Analysis based on the detail submitted is required to assure that a uniform method of depreciation is applied in each year. Under the current Blue Cross contracts the straight line method is mandatory. Any significant increases in depreciation would be the result of improvements in the facilities or purchase of equipment. This must be verified with the hospital if the budget does not indicate the nature and amount.

4. *Interest*—Capital indebtedness interest should be decreasing each year unless additional loans for the purchases of depreciable assets are made. This expense must be correlated with the depreciation detail to determine the accuracy and reasonableness of the projections. Working capital interest will be reviewed for any significant changes. Justification could be requested from the hospital through review of budgeted income statements to determine the working capital projections and the need for borrowing. Consideration must also be given to the interest rates and future economic projections.

Finally, the budget is reviewed to determine any new or material changes in services or facilities. The hospital should disclose this detail as part of the budget submission. An in-depth analysis (usually requiring additional documentation from the hospital) is performed on such

Exhibit 30

costs including the verification of approval of outside agencies if required and the methodology utilized in establishing the cost estimate. These estimates must reflect whenever possible the trends and past experience of the individual hospital. Only accurate and reasonable estimates are approved for inclusion in the overall operating budget.

Exhibit 31

ACTUAL AND PROJECTED PER DIEM HOSPITAL COSTS IN PHILADELPHIA

Calendar Years 1964-1977

1964	$ 29.27	
1965	$ 31.56	
1966	$ 36.31	
1967	$ 41.77	
1968	$ 49.99	
1969	$ 63.11	
1970	$ 73.70	
1971	$ 83.23	
1972	$ 92.98	
1973	$103.07	
1974	$117.84	
1975	$141.88	(estimate)
1976	$170.26	(estimate)
1977	$201.25	(estimate)

Exhibit 32

OUTPATIENT CASES
PER 1,000 SUBSCRIBERS

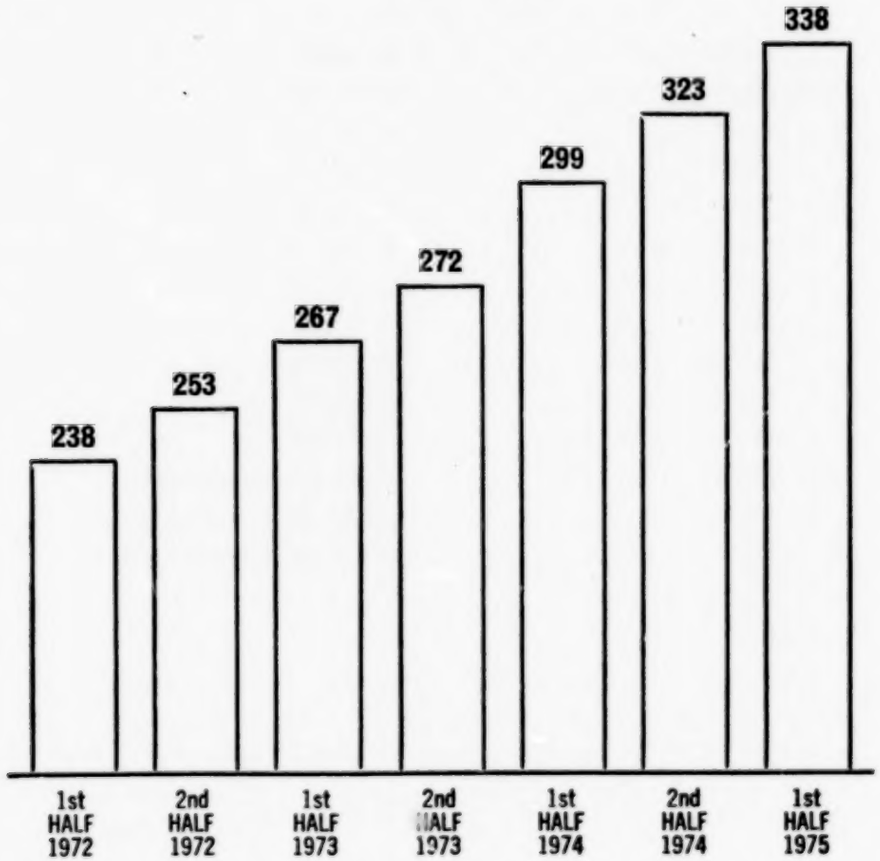
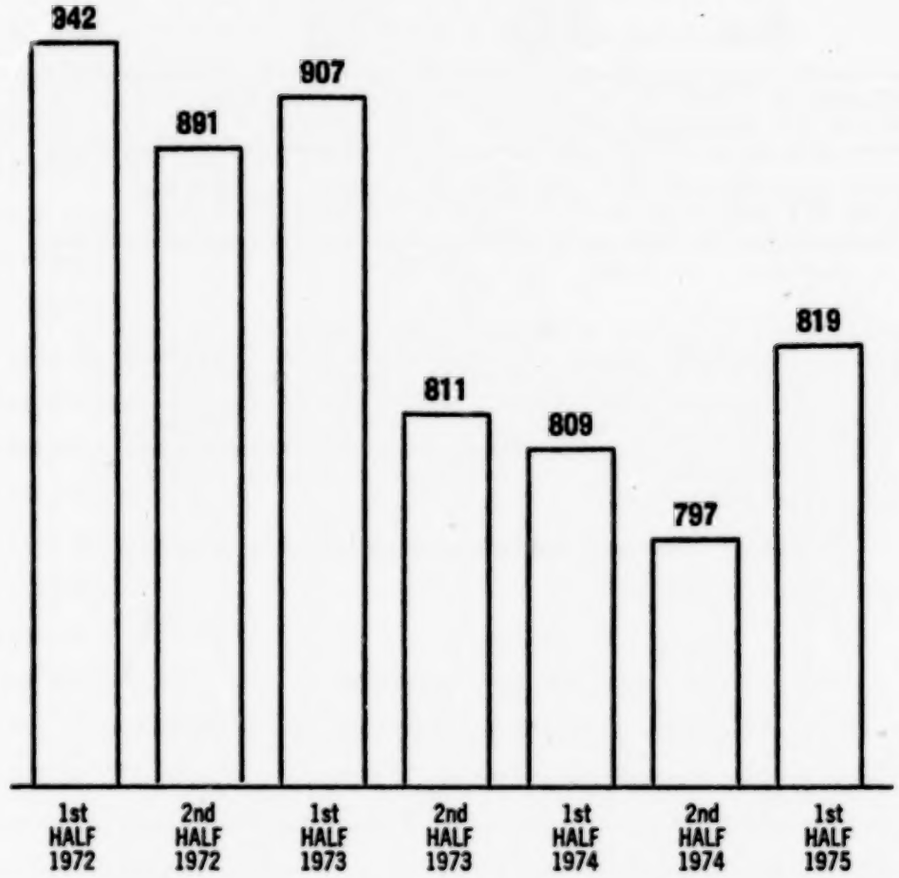


Exhibit 32

INPATIENT DAYS FOR
EACH 1,000 SUBSCRIBERS



PRIOR PRINTER'S NO. 10 Printer's No. 978

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 10 Session of 1975

INTRODUCED BY COPPERSMITH, FEIBMAN, DOUGHERTY, MURRAY, LEWIS, NOLAN AND MESSINGER, JANUARY 7, 1975

SENATOR COPPERSMITH, PUBLIC HEALTH AND WELFARE, AS AMENDED, JUNE 24, 1975

AN ACT

Relating to health care, prescribing the powers and duties of the Department of Health, establishing and providing the powers and duties of the ~~Health Care Policy Board~~ STATEWIDE HEALTH COORDINATING COUNCIL; providing for licensure, rate approval, certification of need of health care providers; creating a health advocate; ~~and the Deputy Secretary for Health Care Facilities~~ prescribing penalties; and making an appropriation. <-- <--

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

ARTICLE I

Preliminary Provisions

Section 101. Short Title.--This act shall be known and may be cited as the "Comprehensive Health Care Act."

Section 102. Purposes.--The General Assembly finds as a fact that the continuously increasing cost of health care services threatens the health and welfare of citizens of the Commonwealth by impairing the ability of citizens to obtain high quality, economical and readily available health care. The General Assembly also finds that the health and welfare of Pennsylvania citizens will be enhanced by the orderly and economical

distribution of health care resources. To achieve such distribution of resources requires governmental intervention to insure the development and organization of a coordinated and comprehensive system of health care. The goal of such a system is to enhance the public health and welfare by insuring that needed health care is available to everyone at a fair and reasonable cost; that the health care delivery system is responsive and adequate to the needs of all citizens; that health care services and facilities are most efficiently and effectively used; that consumers have meaningful input regarding the delivery of care; that health care cost inflation is limited; that unnecessary duplication, fragmentation, and dehumanization of health care services and facilities are minimized; that health care services and facilities meet high quality standards; that relevant information on the cost and quality of health care is disclosed to the public to the maximum extent possible; and, that all citizens receive humane, courteous and dignified treatment. In developing such a coordinated and comprehensive health care system, it is the policy of the Commonwealth to foster responsible private operation and ownership of health care facilities, to encourage innovation and continuous development of improved methods of health care and to aid efficient and effective planning using local agencies.

Section 103. Definitions.--As used in this act:

"ACT" MEANS THE COMPREHENSIVE HEALTH CARE ACT. <--

"Consumer" means a natural person who uses or potentially will use the services of a provider of health care, provided, however, that the consumer is not any of the following: a provider of health care; an administrator, employee or

representative of a provider of health care, an administrator, employee or representative of a third party payor as defined in this act; a member of the governing board of a provider or a third party payor, unless serving on such board as a designated consumer representative; ~~or~~ a person with a substantial financial interest in a provider, a third party payor or a major vendor of goods and services to providers or third party payors; OR A MEMBER OF THE HEALING ARTS.

"COUNCIL" MEANS THE STATEWIDE HEALTH COORDINATING COUNCIL ESTABLISHED PURSUANT TO FEDERAL PUB.L.93-641.

"Department" means the Department of Health.

"Health care facility" means a general, tuberculosis, mental, chronic disease or other type of hospital, except a Federal facility or State mental hospital; an ambulatory surgical center; a physical rehabilitation facility; a skilled or intermediate care nursing facility; a radiology laboratory; a renal dialysis center; a diagnostic center; OR a home health care agency; ~~or a clinical laboratory;~~ regardless of whether such health care facility is for-profit, nonprofit or governmental; but not an office used exclusively for the private practice of the healing arts or a program which renders treatment or care for drug or alcohol abuse or dependence unless located within a health care facility or a facility providing treatment solely on the basis of prayer or spiritual means. ~~A health care facility, as defined, which is conducted by a religious organization for the purpose of providing health care services exclusively to clergymen or other persons in a religious profession who are members of a religious denomination, is included for the purpose of licensure only.~~

"Health care provider" means a person who operates a health

care facility.

"Local agency" means any area-wide comprehensive health planning agency qualified under Federal Public Law 89-749 or ~~where no such agency exists, any consumer controlled regional health planning agency recognized as the exclusive planning agency by the department.~~ A SUCCESSOR AGENCY QUALIFIED UNDER FEDERAL PUB.L.93-641 OR SUBSEQUENT FEDERAL LAW.

"Person" means a natural person, corporation, partnership, association, the Commonwealth and any local governmental unit, authority and agency thereof.

"Policy Board" OR "BOARD" means the Health Care Policy Board created under the provisions of section 301.

"Rates" mean all moneys payable to providers for health care services, including fees, charges, and cost reimbursement.

"Secretary" means the Secretary of the Department of Health of the Commonwealth of Pennsylvania.

"Third party payor" means: (i) any stock or mutual insurance company, association or exchange issuing or servicing any hospitalization, accident and health, or major medical insurance policy; (ii) any hospital plan corporation, as defined in ~~the act of November 15, 1972 (P.L.1063, No.271);~~ 40 PA.C.S. § 6101 (RELATING TO DEFINITIONS); (iii) any professional health service corporation, as defined in ~~the act of November 15, 1972 (P.L.1063, No.271);~~ ~~or~~ 40 PA.C.S. § 6101; or (iv) THE COMMONWEALTH, WITH RESPECT TO PAYMENTS MADE TO HEALTH CARE PROVIDERS PURSUANT TO TITLE XIX OF THE FEDERAL SOCIAL SECURITY ACT; OR (V) any person, partnership, corporation, joint venture or other association which administers the provision of health care services on a prepaid basis; or which administers reimbursements for the provision of health care services

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DELIVERED by any health care provider or health care facility subject to the provisions of this act.

ARTICLE II

Powers and Duties of the Department

Section 201. Powers and Duties of the Department.--The department shall have the power and its duties shall be:

(1) To issue licenses to health care providers qualified under the provisions of this act and to renew, suspend, and revoke licenses.

(2) To issue and ~~renew certificates of need and amended or supplemental~~ AMEND certificates of need whenever it finds that the applicants qualify therefor under the provisions of this act. ~~and to revoke, limit or modify certificates of need held by health care providers in accordance with this act.~~

(3) To approve rates to be paid to ~~health care~~ HOSPITAL providers and to approve contracts between ~~health care~~ HOSPITAL providers and third party CONTRACT payors.

(4) To conduct, EITHER DIRECTLY OR BY CONTRACTING WITH OTHER QUALIFIED AND EXPERIENCED PERSONS, inspections, investigations, audits, inquiries and hearings on matters relating to health care facilities or services, and such related matters as may be necessary to carry out the purposes and provisions of this act.

(5) To research and, AFTER ADOPTION BY THE COUNCIL, publish annually a report on the regulation of health care facilities in Pennsylvania and ~~in conjunction with the local agency develop, publish and periodically update a long-range plan for a coordinated comprehencive Pennsylvania health care system.~~ TO RESEARCH AND PREPARE ANNUALLY A PRELIMINARY STATE HEALTH PLAN FOR PENNSYLVANIA AND IN CONJUNCTION WITH THE COUNCIL PUBLISH A STATE HEALTH PLAN FOR PENNSYLVANIA.

(6) With respect to health care facilities to investigate, and report to the Auditor General, upon every application to the Auditor General made by any institution, corporation, or unincorporated association, desiring to give a mortgage under the provisions of the act of April 29, 1915 (P.L.201, No.112), entitled "An act making mortgages, given by benevolent, charitable, philanthropic, educational, and eleemosynary institutions, corporations, or unincorporated associations, for permanent improvements and refunding purposes, prior liens to the liens of the Commonwealth for the appropriation of moneys; providing a method for the giving of such mortgages, and fixing the duties of the Auditor General and Board of Public Charities in connection therewith."

(7) To furnish such staff support and expertise to the ~~Policy Board~~ COUNCIL as may be needed by them to perform their responsibilities.

(8) To minimize the administrative burden on health care providers by eliminating unnecessary duplication of financial and operational reports and to the extent possible coordinating reviews and inspections performed by Federal, State, local and private agencies.

(9) To furnish consultation and advice to health care providers relating to financial planning and the securing of capital funds for the purchase, acquisition or construction of health care facilities.

(10) To ~~make~~ SET reasonable ~~assessments against~~ FEES TO BE PAID BY providers ~~for the cost of conducting the inspection for licensure.~~ IN CONNECTION WITH APPLICATIONS, RENEWALS, FILINGS AND PETITIONS AUTHORIZED BY THE ACT.

(11) To hold formal hearings in accordance with the act of

June 4, 1945 (P.L.1388, No.442), known as the "Administrative Agency Law" and informal hearings, conferences and other oral proceedings and receive written comments, sworn affidavits and other writings on matters for decision by the department.

(12) To designate the local agency for purposes of certification of need and to contract with such local agencies for reimbursement by the department for conducting such certification.

(13) TO ADOPT AFTER CONSULTATION WITH THE COUNCIL REGULATIONS FOR LICENSURE AND THE PROCEDURES TO BE FOLLOWED IN ACCORDANCE WITH THE ACT. <--

(14) TO ADOPT AFTER CONSULTATION WITH THE COUNCIL REGULATIONS FOR CERTIFICATION OF NEED AND THE PROCEDURES TO BE FOLLOWED IN ACCORDANCE WITH THE ACT.

(15) TO GRANT WAIVERS FROM RULES AND REGULATIONS WHEN FOUND TO BE IN THE PUBLIC INTEREST AND CONSISTENT WITH THE PURPOSES OF THE ACT.

(16) TO ADOPT AFTER CONSULTATION WITH THE COUNCIL REGULATIONS FOR APPROVAL OF RATES AND CONTRACTS AND THE PROCEDURES TO BE FOLLOWED IN ACCORDANCE WITH THE ACT.

(17) TO ADOPT AFTER CONSULTATION WITH THE COUNCIL RULES AND REGULATIONS REGARDING UNIFORM SYSTEMS OF ACCOUNTING AND REPORTING.

(18) TO ADOPT AFTER CONSULTATION WITH THE COUNCIL RULES AND REGULATIONS IN REGARD TO DISCLOSURE OF THE CONTRACTS OF OTHER FINANCIAL ARRANGEMENTS BETWEEN HEALTH CARE PROVIDERS AND HOSPITAL BASED MEDICAL SPECIALISTS PURSUANT TO SECTION 608.

(19) TO ADOPT OTHER REGULATIONS NECESSARY OR CONVENIENT TO CARRY OUT THE PURPOSES AND PROVISIONS OF THE ACT.

~~(13)~~ (20) To implement a system of monitoring and evaluation <--

by the department of the efficiency and effectiveness of its own operations and to report the results annually to the Governor, the General Assembly and the Policy Board.

~~(14)~~ (21) To enforce the rules and regulations adopted by the ~~Policy Board.~~ DEPARTMENT. <--

~~(15)~~ (22) To exercise all other powers which are reasonably related to the effective implementation of this act. <--

ARTICLE III

~~Organization and Powers and Duties of the Health Care Policy Board, Council on Resources, the Health Advocate, and the Deputy Secretary for Health Care Facilities~~ <--

~~Section 301. Health Care Policy Board.--The Policy Board shall consist of eleven members, ten of whom shall be appointed by the Governor, and the Secretary of Health or, upon his designation, the Deputy Secretary for Health Care Facilities. Of the members first appointed, two shall be appointed for a term of one year, three for a term of two years, two for a term of three years and three for a term of four years. Thereafter, appointments shall be made for four-year terms. A vacancy occurring during a term shall be filled for the unexpired term. The members of the Policy Board shall be chosen for their training, experience and familiarity with the delivery of health care or for other ability and experience which will materially add to the deliberations of the board. Of the ten members appointed to the board, six shall be consumers and four shall be providers or third-party payors. The Governor shall have the power to designate the chairman and adjust the composition of the board to meet changing requirements of Federal statutes and regulations. Six members shall constitute a quorum.~~

~~No member may participate in any action or decision concerning any matter in which the member has a substantial economic interest.~~

~~The board may have a professional staff of such size and qualifications as the board shall determine.~~

ORGANIZATION AND POWERS AND DUTIES OF THE HEALTH CARE POLICY BOARD, STATEWIDE HEALTH COORDINATING COUNCIL AND THE HEALTH ADVOCATE <--

SECTION 301. HEALTH CARE POLICY BOARD.--THE POLICY BOARD SHALL CONSIST OF 19 MEMBERS APPOINTED BY THE GOVERNOR. OF THE MEMBERS FIRST APPOINTED, FOUR SHALL BE APPOINTED FOR A TERM OF ONE YEAR, FIVE FOR A TERM OF TWO YEARS, FIVE FOR A TERM OF THREE YEARS AND FIVE FOR A TERM OF FOUR YEARS. THEREAFTER, APPOINTMENTS SHALL BE MADE FOR FOUR-YEAR TERMS. A VACANCY OCCURRING DURING A TERM SHALL BE FILLED FOR THE UNEXPIRED TERM. THE MEMBERS OF THE POLICY BOARD SHALL BE CHOSEN FOR THEIR TRAINING, EXPERIENCE AND FAMILIARITY WITH THE DELIVERY OF HEALTH CARE OR FOR OTHER ABILITY AND EXPERIENCE WHICH WILL MATERIALLY ADD TO THE DELIBERATIONS OF THE BOARD. OF THE 19 MEMBERS APPOINTED TO THE BOARD, FOUR SHALL BE MEMBERS OF THE GENERAL PUBLIC WHO QUALIFY AS CONSUMERS, TWO SHALL BE REPRESENTATIVES OF ORGANIZED LABOR, TWO SHALL BE MEMBERS OF THE BUSINESS COMMUNITY, TWO SHALL BE THIRD PARTY CONTRACT PAYORS, ONE SHALL BE A THIRD PARTY PAYOR WHO IS NOT A THIRD PARTY CONTRACT PAYOR, ONE SHALL BE A PHYSICIAN, ONE SHALL BE A NON-PHYSICIAN MEMBER OF THE HEALING ARTS, TWO SHALL BE FROM HOSPITAL MANAGEMENT OR BOARDS, ONE SHALL BE REPRESENTATIVE OF NURSING HOMES, ONE SHALL BE A REPRESENTATIVE OF OTHER CLASSES OF PROVIDERS AND TWO SHALL BE FROM ANY CLASS OF PROVIDER. THE GOVERNOR SHALL HAVE THE POWER TO DESIGNATE THE CHAIRMAN AND ADJUST THE COMPOSITION OF THE BOARD

TO MEET CHANGING REQUIREMENTS OF FEDERAL STATUTES AND REGULATIONS. TEN MEMBERS SHALL CONSTITUTE A QUORUM.

NO MEMBER MAY PARTICIPATE IN ANY CONSULTATION, ACTION OR DECISION CONCERNING ANY MATTER IN WHICH THE MEMBER HAS A SUBSTANTIAL ECONOMIC INTEREST WITHOUT FULL DISCLOSURE OF THE NATURE AND EXTENT OF THE INTEREST.

FOR ADMINISTRATIVE PURPOSES, THE BOARD SHALL BE A COMPONENT PART OF THE COUNCIL.

Section 302. Health Care Policy Board; Powers.--The Health Care Policy Board shall have the power and its duties shall be:

(1) To review and integrate the requirements of this act and other State and Federal laws pertaining to the delivery of health care and to consult with Federal, State, local and private agencies involved in the health care system.

(2) To create such committees or advisory groups which it deems necessary to advise and make recommendations, suggestions or objections with respect to proposed regulations or to propose and recommend regulations.

(3) To annually adopt a report to the Governor, the General Assembly and the public on the regulation of health care facilities in Pennsylvania. ~~and to review and adopt a long-range plan, with periodic updates, for a coordinated comprehensive Pennsylvania health care system.~~ <--

(4) To ~~adopt~~ CONSULT WITH THE SECRETARY PRIOR TO ADOPTION OF regulations for licensure and the procedures to be followed in accordance with this act. <--

(5) To ~~adopt~~ CONSULT WITH THE SECRETARY PRIOR TO ADOPTION OF regulations for certification of need and the procedures to be followed in accordance with this act. <--

~~(6) To grant waivers upon the recommendation of the~~ <--

~~secretary from rules and regulations when found to be in the public interest and consistent with the purposes of this act. Whenever the secretary recommends to the Policy Board the grant of a waiver, notice of such recommendation, with a brief description of the content of the waiver sought, shall be published in the Pennsylvania Bulletin at least 30 days prior to consideration by the board. The Policy Board shall provide to any person interested as a provider, consumer or third party payor, reasonable opportunity to be heard prior to making a determination.~~

~~(7)~~ (6) To ~~adopt~~ CONSULT WITH THE SECRETARY PRIOR TO ADOPTION OF regulations for approval of rates and contracts and the procedures to be followed in accordance with this act. <--

~~(8)~~ (7) To ~~adopt~~ CONSULT WITH THE SECRETARY PRIOR TO THE ADOPTION OF rules and regulations regarding uniform systems of accounting and reporting. <--

~~(9)~~ (8) To ~~adopt~~ CONSULT WITH THE SECRETARY PRIOR TO THE ADOPTION OF rules and regulations in regard to disclosure of the contracts or other financial arrangements between ~~health care~~ HOSPITAL providers and hospital based medical specialists pursuant to Section 608. <--

~~(10) To establish a schedule of reasonable fees with respect to applications, renewals, or filings to cover the department's administrative cost of processing.~~ <--

~~(11)~~ (9) To assume ALL the existing powers and duties of the Advisory Health Board in the ~~Department of Health.~~ <--

~~(12) To prescribe regulations for processes of monitoring and evaluation of the operation of providers of health care.~~

~~(13) To adopt other regulations necessary or convenient to carry out the purposes and provisions of this act.~~ DEPARTMENT <--

EXCEPT THOSE RELATING TO:

(A) VITAL STATISTICS AS SET FORTH IN SECTION 2104 OF THE ACT OF APRIL 9, 1929 (P.L.177, NO.175), KNOWN AS "THE ADMINISTRATIVE CODE OF 1929."

(B) HEALTH SERVICES FOR COUNTIES OR OTHER POLITICAL SUBDIVISIONS AS SET FORTH IN SECTION 2111(D) OF THE ACT OF APRIL 9, 1929 (P.L.177, NO.175), KNOWN AS "THE ADMINISTRATIVE CODE OF 1929."

(C) SCHOOL CHILDREN IMMUNIZATION AS SET FORTH IN SECTION 2111(C.1) OF THE ACT OF APRIL 9, 1929 (P.L.177, NO.175), KNOWN AS "THE ADMINISTRATIVE CODE OF 1929."

~~(14)~~ (10) To carry out such other responsibilities as may be conferred by this act OR REQUESTED BY THE SECRETARY. <--

Section 303. ~~Council on Resources.--(a) The council on resources shall consist of the executive committee of the Statewide Comprehensive Health Planning Council. A majority of the membership shall constitute a quorum. For purposes of this act, the Statewide Council shall elect the membership of its executive committee so as to reflect the same proportion of consumers which exists on the Statewide Council.~~

~~(b) The council on resources~~ STATEWIDE HEALTH COORDINATING COUNCIL.--(A) THE STATEWIDE HEALTH COORDINATING COUNCIL shall review and integrate the requirements of this act and State and Federal laws, rules and regulations relating to certification of need. It shall review and make recommendations, suggestions or objections to any PROPOSED rule or regulation submitted to it by the Policy Board OR THE DEPARTMENT. <--

~~(c)~~ (B) The Policy Board OR DEPARTMENT may request the council ~~on resources~~ to study and review all or any portion of the laws, rules and regulations relating to certification of

need. The council shall report to the Policy Board OR DEPARTMENT within the time prescribed. ~~by the Policy Board in making its request for the study.~~

~~(d)~~ (C) The department may assign to the council any advisory responsibilities required by Federal law or regulations pertaining to need certification of health care facilities.

Section 304. Policy Board and Council on Resources: Compensation; Expenses.--Each member of the council shall be paid traveling and other necessary expenses, and compensation at a rate to be determined by the Executive Board. The council may appoint such committees or advisory groups as it deems necessary to advise and assist it in its studies, but nonmembers of the council shall receive no compensation for services or expenses. Members of the Policy Board~~, except the secretary,~~ shall be paid traveling and other necessary expenses and compensation at a rate to be determined by the Executive Board.

Section 305. Health Advocate.--(a) There is hereby created the Health Advocate to represent the interests of users and potential users of health care services in the Commonwealth.

(b) The Health Advocate shall be appointed by the Governor for a term of four years to run concurrently with the gubernatcrial term. The compensation shall be set by the Executive Board. The Health Advocate shall possess the background, independence and judgment required to represent responsibly the interests of users and potential users of health care services.

(c) The Health Advocate shall issue an annual report to the public on the activities of the Health Advocate's office, including the types of complaints received, the results achieved pursuant to such complaints, and continuing problems.

(d) The Health Advocate shall have the power upon petition of consumers or on his own motion:

(1) to initiate or participate in formal or informal proceedings regarding any matter of the department;

(2) to ~~initiate or~~ participate in OR, UPON THE EXHAUSTION OF ADMINISTRATIVE REMEDIES, INITIATE litigation on behalf of consumers regarding health care or health related matters;

(3) to hold public hearings from time to time in various parts of the Commonwealth to solicit consumer views;

(4) to examine any relevant information and records in the possession of any Commonwealth department, board, commission or instrumentality, provided that no confidential information is disclosed or utilized in violation of law; and

(5) to publicize issues relating to matters of health care.

(e) The Health Advocate shall have authority to employ adequate professional and clerical staff and define their duties as may be necessary to carry out the powers and responsibilities imposed by this act. The salaries of the professional and clerical staff shall be set by the Executive Board. For administrative purposes the office of the Health Advocate shall be under the jurisdiction of the Governor's office.

Section 306. ~~Deputy Secretary for Health Care Facilities.--(a) There is hereby created in the Department of Health the Deputy Secretary for Health Care Facilities, who shall be appointed by the Governor and subject to the advice and consent of the Senate.~~

~~(b) The Deputy Secretary for Health Care Facilities shall be chief administrator for implementation of this act, having under his direction the functions of certification of need, licensure and rate approval. The powers, authority, duties or~~

~~responsibilities conferred by this act on the secretary or the department may, unless otherwise indicated, be exercised with equal force and effect by the Deputy Secretary for Health Care Facilities.~~ DELEGATION OF ADMINISTRATIVE RESPONSIBILITY.--THE <--
GOVERNOR MAY DELEGATE ADMINISTRATIVE RESPONSIBILITY FOR ALL OR CERTAIN PROVISIONS OF THE ACT TO ONE OR MORE DEPUTY SECRETARIES IN THE DEPARTMENT. THE POWERS AND DUTIES CONFERRED BY THE ACT ON THE SECRETARY OR DEPARTMENT MAY, UNLESS OTHERWISE INDICATED, BE EXERCISED WITH EQUAL FORCE AND EFFECT BY SUCH DEPUTY OR DEPUTIES.

ARTICLE IV

Administration of the Act

Section 401. Promulgation of Rules and Regulations.--(a) The rules and regulations under this act shall be promulgated by the ~~Policy Board~~ DEPARTMENT under the provisions of the act of July <-- <--
31, 1968 (P.L.769, No.240), known as the "Commonwealth Documents Law" and shall provide fair access and due process to all interested parties in proceedings held to carry out the provisions of this act.

(b) A brief statement ~~of the reason for each substantive provision~~ AND DISCUSSION OF THE MAJOR ISSUES shall accompany <-- <--
publication of proposed regulations and subsequent changes in the Pennsylvania Bulletin, but such statement shall not have the effect of law.

Section 402. Opportunity to Be Heard.--(a) Opportunity to be heard may be granted by means of formal or informal hearings, conferences or other oral proceedings or by written comments, sworn affidavits or other writings on matters for decision by the department as may be deemed necessary by the department to make fair and informed decisions.

(b) Departmental hearings or other oral proceedings may be conducted by such persons as the secretary may designate, ~~including special agents or examiners,~~ provided that no <--
determination or order of the department shall become effective until approved and confirmed by the secretary or such representatives as he may designate for such purpose. ~~other than each special agent or examiner.~~ <--

(c) Persons conducting proceedings under this act shall have the power to subpoena witnesses, to administer oaths and examine witnesses and receive evidence in any locality which the department, having regard to the public convenience and proper discharge of its functions and duties, may designate.

(D) FORMAL HEARINGS SHALL BE CONDUCTED IN ACCORDANCE WITH <--
THE ACT OF JUNE 4, 1945 (P.L.1388, NO.442), KNOWN AS THE "ADMINISTRATIVE AGENCY LAW."

Section 403. Enforcement of Orders.--Orders of the department from which the time for appeal has expired may be enforced by the department in the court of common pleas of the county in which the health care facility is located or in the Commonwealth Court.

Section 404. Investigations and Inquiries.--Any investigation or inquiry authorized by this act shall be limited to the purposes set forth in the departmental order, rule or regulation authorizing the same.

Section 405. Appeals.--The appeal from any action of the department shall be to the Commonwealth Court.

ARTICLE V

Certificate of Need

SECTION 501. HEALTH CARE FACILITIES SUBJECT TO ARTICLE <--
V.--THIS ARTICLE SHALL APPLY ONLY TO THE FOLLOWING CLASSES OF

HEALTH CARE FACILITIES:

(1) A GENERAL TUBERCULOSIS, MENTAL, CHRONIC DISEASE OR OTHER TYPE OF HOSPITAL, EXCEPT A FEDERAL FACILITY OR STATE MENTAL HOSPITAL;

(2) A SKILLED OR INTERMEDIATE CARE NURSING FACILITY, UNLESS CONDUCTED BY A RELIGIOUS ORGANIZATION FOR THE PURPOSE OF PROVIDING CARE EXCLUSIVELY TO CLERGYMEN OR OTHER PERSONS IN A RELIGIOUS PROFESSION WHO ARE MEMBERS OF A RELIGIOUS DENOMINATION;

(3) A HOME HEALTH CARE AGENCY; OR

(4) A RENAL DIALYSIS CENTER.

Section ~~501.~~ 502. Certificate of Need Requisite for Licensure.--No license or reneval thereof to provide health care services shall be issued unless the applicant has a valid certificate of need issued by the department authorizing the use of the facility and the rendering of the services for which the license is to be issued. <--

Section ~~502.~~ 503. Certificate of Need: When Required.--(a) No person shall operate, lease OR ENTER INTO A LEASE or construct OR ENTER INTO A CONTRACT TO CONSTRUCT a health care facility without first obtaining a certificate of need from the department, authorizing such operation, lease or construction. <-- <-- <--

(b) No person operating an existing health care facility under a certificate of need shall make expenditures toward any project which will involve a total capital project cost including the fair market value of any leased property in excess of $100,000 in which he will (i) lease, erect, construct, alter, modernize or improve any building, or (ii) acquire any real property to be used now or in the future for health care purposes except by gift, devise or option, or (iii) lease or

acquire equipment. No person shall make a substantial change in services, as defined by the department, or permanently increase or decrease the bed complement beyond limits set by the department unless such person has first been authorized to do so by the department through the issuance of a new or amended certificate of need.

A HEALTH CARE PROVIDER OR LOCAL AGENCY MAY REQUEST A RULING FROM THE DEPARTMENT REGARDING THE NECESSITY OF OBTAINING A CERTIFICATE OF NEED FOR A PROPOSED CHANGE. THE DEPARTMENT SHALL MAKE SUCH RULING IN A TIMELY FASHION. <--

(c) At least 30 days prior to substantial reduction of a service or a permanent decrease in the bed complement, the provider shall notify the local agency and the department of its intended actior. If the local agency does not notify the provider of its objection within 30 days, the provider may make the specified change and an amended certificate of need will be issued automatically. If the local agency does notify the provider of its objections within 30 days, the procedures of section 504 shall apply.

~~Section 503. Changes Without Issuance of Certificate of Need or Mandated Changes of Use.--(a) A certificate of need shall not be required whenever a provider of health care services is directed to alter, modernize or improve a building or acquire equipment under a Federal or State law, rule, regulation or order, but in such event, notice of the specific changes to be made shall be given by the health care provider to the department and the local agency, and the certificate of need of such facility shall be amended accordingly.~~ <--

~~(b) When other changes are made which do not require a new or amended certificate of need, such changes must be reported to~~

~~the department and the local agency at a reasonable time before such change is made.~~

Section 504. Certificates of Need; Application; Issuance.--(a) A person desiring to obtain~~, renew~~ or amend a certificate of need shall apply ~~to the local agency, supplying to it~~ BY SENDING A LETTER OF INTENT TO THE DEPARTMENT, WHICH WILL THEN DIRECT SUCH PERSON AND THE LOCAL AGENCY IN THE MANNER TO PROCEED. SAID PERSON SHALL SUPPLY such information as is required by rules and regulations. A copy of the application shall be given to SIMULTANEOUSLY the department ~~at the same time an application is made to a~~ AND THE local agency. The local agency's recommendations or objections shall be forwarded to the department and considered by the council ~~as recourses~~ if filed with the department within 60 days of the date the applicant submitted the completed application to the local agency. Council recommendations or objections, if any, shall be filed with the department within 60 days of the receipt of a copy of the application by the department or within 15 days of the timely filing of the local agency recommendations or objections whichever shall last occur. The department shall consider recommendations or objections of the council or local agency unless they are not timely filed with the department. If not timely filed, the department shall act upon the application without the recommendations or objections. FAILURE OF THE LOCAL AGENCY TO TIMELY FILE RECOMMENDATIONS OR OBJECTIONS SHALL NOT HAVE THE EFFECT OF A POSITIVE DETERMINATION AND THE DEPARTMENT MAY EXTEND THE REVIEW PERIOD BY 30 DAYS IN ORDER TO PROVIDE ADEQUATE TIME FOR STUDY AND REVIEW OF THE PROPOSAL BY THE DEPARTMENT IN THE ABSENCE OF SUCH RECOMMENDATIONS OR OBJECTIONS. Whenever objections are timely filed, the department shall

promptly set a date for a hearing on the application. The department may on its own motion or at the request of any person hold a hearing on any application.

IF THE DEPARTMENT INTENDS TO DENY AN APPLICATION, THE APPLICANT HAS THE RIGHT TO A FORMAL HEARING IN ACCORDANCE WITH THE ACT OF JUNE 4, 1945 (P.L.1388, NO.442), KNOWN AS THE "ADMINISTRATIVE AGENCY LAW." THE FINDINGS, CONCLUSIONS AND RECOMMENDATIONS OF THE HEARING OFFICER SHALL BE CERTIFIED TO THE SECRETARY.

(b) The department shall act upon the application within 30 days of the recommendation of the local agency or of the council, whichever shall last occur, BUT IN NO EVENT LATER THAN 90 DAYS FROM RECEIPT OF A COMPLETED APPLICATION, by granting, amending, REMANDING or refusing the requested certificate of need or by conducting a hearing on the application. Notice of filing applications for certificates of need or amendments ~~or renewals~~ thereof under subsection (a) shall be published in the Pennsylvania Bulletin ~~and any~~ AND SHALL BE PROVIDED TO THE APPROPRIATE NEWS MEDIA SERVING THE AREA IN WHICH THE PROPOSED PROJECT WILL BE LOCATED. ANY person interested as a consumer, provider or third party payor may file objections within 30 days of publication with the department setting forth specifically the reasons therefor.

~~(c) An application for a certificate of need shall be recommended, approved and issued when:~~

~~(1) there is a community need for the facility;~~

~~(2) the necessary resources are available to operate the facility;~~

~~(3) it is a prudent use of resources considering the alternative uses for such resources considering the scope of~~

types of services to be offered and considering existing facilities in adjacent areas. Noncompliance with the State plan adopted by the Policy Board may be considered by the department as a proper basis for refusal of a certificate of need;

(4) the applicant is reasonably likely to fulfill licensure requirements;

(5) the proposed health care facility is economically feasible considering anticipated volume of care and the rates to be charged.

If the health care facility or service is to be used primarily for patients from an area larger than the immediate locality or community in which it is located, certificate of need shall not be refused on the ground that the immediate locality or community has no need for the health care facility or service and the application shall be considered in terms of need of the larger area.

The local agency may take into consideration the religious orientation of a health care provider and the community to be served; it may also take into consideration, as may be appropriate, different methodologies of treatment.

Section 505. Waiver from Rules.--If the local agency has recommended a certificate of need which has been refused by the department on the ground that the issuance of such a certificate is in violation of the rules and regulations or of the State plan, the applicant may upon recommendation by the secretary apply to the Policy Board for a waiver from the rules and regulations or plan which may be granted where there is a proven exceptional need and it is consistent with the purposes of this act. No appeal shall be allowed from the refusal of the Policy Board to grant a waiver.

Section 506. Expiration of Certificate of Need.--A certificate of need shall remain effective for a period of at least three but no more than 5 years, as determined by the board, providing the facilities and services authorized are in use. Renewal of a certificate shall be determined by the department only after review and recommendation by the local agency. Standards for renewal shall be based upon the standards for issuance of a certificate. The department may provide for simplified procedures for renewal of a certificate.

Section 507. Revocation and Amendment of Certificate of Need.--(a) The department may, upon recommendation of the local agency, after due notice to the holder thereof and upon request a hearing thereon, revoke or amend a certificate of need, having due regard for the financial burden such changes may impose, should it find that the need for the service or health care facility no longer exists in the community or is not being adequately fulfilled by the service or health care facility. The department also, upon recommendation of the local agency may withdraw a certificate of need of one health care facility as to a particular service to permit the furnishing of the same service by another health care facility applying to furnish the service if the department shall find that the transfer of service is in the interest of the best use of the facilities in the community or area, is in the public interest and that the change will provide more efficient utilization of health care services in the community or area.

(b) The Policy Board shall in cooperation with the council on resources and the local agencies develop and promulgate standards for nonrenewal or revocation of a certificate of need. In cases where nonrenewal, revocation or denial of an

~~application is contemplated, the local agency and the department shall whenever possible seek in cooperation with the provider to determine and implement a satisfactory alternative use for the facility or proposed facility.~~

(C) THE DEPARTMENT SHALL DEVELOP BY REGULATION GENERAL PRINCIPLES THAT MUST BE EMPLOYED BY THE LOCAL AGENCIES AND THE DEPARTMENT IN THE DETERMINATION OF CERTIFICATE OF NEED APPLICATIONS. THE PRINCIPLES MUST PROVIDE FOR, BUT NEED NOT BE LIMITED TO, THE FOLLOWING CONSIDERATIONS: <--

(1) THE NEED FOR HEALTH CARE SERVICES IN THE AREA AND THE REQUIREMENTS OF THE POPULATION TO BE SERVED BY THE APPLICANT.

(2) THE AVAILABILITY AND ADEQUACY OF HEALTH CARE SERVICES IN THE AREA'S EXISTING FACILITIES.

(3) THE AVAILABILITY AND ADEQUACY OF OTHER SERVICES IN THE AREA WHICH MAY SERVE AS ALTERNATIVES OR SUBSTITUTES FOR THE WHOLE OR ANY PART OF THE SERVICES TO BE PROVIDED BY THE PROPOSED FACILITY.

(4) THE POSSIBLE ECONOMIES AND IMPROVEMENT IN SERVICES THAT MAY BE DERIVED FROM OPERATION OF JOINT, COOPERATIVE, OR SHARED HEALTH CARE RESOURCES.

(5) THE DEVELOPMENT OF COMPREHENSIVE SERVICES FOR THE COMMUNITY TO BE SERVED, WHETHER DIRECTLY OR INDIRECTLY, SUCH AS BY AFFILIATION.

(6) MANAGEMENT AND FINANCIAL CAPABILITIES OF THE APPLICANT AND THE LIKELIHOOD OF FULFILLING LICENSURE REQUIREMENTS BASED ON AVAILABLE INFORMATION, WHICH SHALL INCLUDE THE HISTORY OF COMPLIANCE WITH LICENSURE STANDARDS IN OTHER HEALTH CARE FACILITIES OPERATED BY THE APPLICANT.

(7) INNOVATION IN THE DELIVERY OF HEALTH CARE SERVICES.

(8) THE INTERESTS OF A DEFINED CULTURAL, RELIGIOUS, OR

ETHNIC MINORITY IN RECEIVING CARE, PARTICULARLY LONG TERM CARE, IN AN ATMOSPHERE REFLECTIVE OF THAT CULTURAL, RELIGIOUS, OR ETHNIC HERITAGE.

(9) THE LEGITIMATE INTERESTS OF AN UNDERSERVED SECTION OF A LARGER COMMUNITY OR REGION THAT MAY HAVE SUFFICIENT HEALTH CARE RESOURCES WHEN VIEWED AS A WHOLE.

(10) THE NEED FOR A FACILITY OF SERVICES OF A NATURE THAT WILL SERVE PATIENTS FROM AN AREA LARGER THAN THE IMMEDIATE COMMUNITY IN WHICH IT IS LOCATED.

(11) THE ECONOMY OF SCALE OF THE INDIVIDUAL PROVIDER AND THE BENEFITS IN REGARD TO COSTS AND QUALITY THAT THE PROPOSED CHANGES WOULD HAVE UPON AN APPLICANT WHO IS AN EXISTING PROVIDER.

(12) THE DIFFERENCES IN THE NATURE OF CARE OR MODALITY OF TREATMENT IN PROPOSED APPLICATIONS FROM EXISTING RESOURCES WHICH MAY HOLD THE SAME LICENSE CATEGORY.

(D) THE PRINCIPLES ISSUED BY THE DEPARTMENT SHALL FURTHER PROVIDE FOR APPROVAL OF A CERTIFICATE OF NEED WHEN THE DEPARTMENT FINDS THAT THE PROPOSED ALTERATIONS, MODERNIZATIONS, IMPROVEMENTS OR ACQUISITION OF EQUIPMENT ARE REQUIRED UNDER A FEDERAL OR STATE LAW, RULE, REGULATION OR ORDER.

(E) IN EVALUATING FOR APPROVAL A CERTIFICATE OF NEED APPLICATION, THE DEPARTMENT MAY RELY UPON A FORMULA-BASED ESTIMATION OF NEED, AS CONTAINED IN THE STATE HEALTH PLAN, AS PRESUMPTIVE EVIDENCE OF THE COMMUNITY NEED FOR THE PROPOSAL UNDER SUBSECTION (C). THE APPLICANT OR OTHER INTERESTED PARTIES MAY OFFER EVIDENCE TO DEMONSTRATE THAT THE NEED IS HIGHER OR LOWER THAN THE ESTIMATE IN THE STATE HEALTH PLAN. IN MAKING ITS FINAL DETERMINATION ON WHETHER A PROPOSAL PROMOTES THE PUBLIC INTEREST, THE DEPARTMENT SHALL WEIGH, BALANCE AND CONSIDER THE

COMPLEXITIES OF EACH CASE IN LIGHT OF THE STATE HEALTH PLAN AND ITS DESCRIPTIVE AND QUANTITATIVE CRITERIA AND IN LIGHT OF ALL THE PRINCIPLES FOR DETERMINING NEED SET FORTH BY THE DEPARTMENT.

(F) APPROVAL OF A CERTIFICATE OF NEED SHALL TERMINATE 12 MONTHS AFTER THE DATE OF SUCH APPROVAL UNLESS THE APPLICANT HAS COMMENCED IMPLEMENTATION OF THE PROJECT AND IS DILIGENTLY PURSUING THE SAME TO COMPLETION AS DETERMINED BY THE DEPARTMENT. THE DEPARTMENT MAY EXTEND AN APPROVAL FOR UP TO AN ADDITIONAL 12 MONTHS FOR GOOD CAUSE SHOWN.

Section ~~508~~ 505. Appeals.--The action of the department upon an application for a certificate of need or for ~~renewal,~~ amendment ~~or revocation~~ thereof may be appealed to the Commonwealth Court by the applicant. ~~or by the local agency, having timely filed its recommendations or objections~~ Appeals shall be taken by filing notice of appeal with the Commonwealth Court within 30 days of notice of the department's action. <--

SECTION 506. IMPLEMENTATION.--THE DEPARTMENT SHALL IMPLEMENT CERTIFICATE OF NEED NO LATER THAN SIX MONTHS FROM THE EFFECTIVE DATE OF THE ACT. <--

ARTICLE VI

Licensure

Section 601. Licensure.--No person shall establish, maintain or operate a health care facility without first having obtained a license therefor issued by the department.

Section 602. Application for License.--Any person desiring to secure a license for conducting, maintaining and operating a health care facility shall submit an application therefor to the department upon forms prepared and furnished by it, containing such information as the department considers necessary to determine that the health care provider and the health care

facility meet the requirements of licensure under the provisions of this act and the rules and regulations relating to licensure. Application for renewal of a license shall be made upon forms prepared and furnished by the department and shall contain such information as may be necessary to determine whether the license should be renewed.

Section 603. Issuance of License.--(a) A health care provider to which a certificate of need has been issued, making application, shall be issued a license when the following standards have been met:

(1) that there is compliance with section ~~601~~ 502; <--

(2) that there is a compliance with the ~~departmental~~ rules and regulations pertaining to licensure ADOPTED BY THE DEPARTMENT TO CARRY OUT THE PURPOSES AND PROVISIONS OF THE ACT. <--

In developing rules and regulations for licensure the department shall take into consideration the standards of the Joint Commission on Accreditation of Hospitals, the Committee on Hospital Accreditation of the American Osteopathic Association and such other accrediting bodies as the board may find appropriate.

(b) When a health care provider operates more than one health care facility, each health care facility providing services to a different segment of the population and operating in autonomous or semi-autonomous fashion with respect to other facilities operated by the same provider shall require a separate license.

Section 604. Provisional License.--When there are numerous deficiencies or a serious specific deficiency in compliance with applicable statutes, ordinances or regulations, and when the department finds the applicant is taking appropriate steps to

correct the deficiencies in accordance with a timetable agreed upon by the department, the department may issue a provisional license for a specified period of not more than 4 SIX months <-- which may be renewed ~~twice~~ THREE TIMES at the discretion of the <-- department. Upon overall compliance, a regular license shall be issued immediately.

Section 605. Issuance of a Modified License.--When the certificate of need for a facility is amended as to services which can be offered, the department shall ~~automatically~~ issue a <-- modified license for those services contained in the amended certificate of need UPON DEMONSTRATION OF COMPLIANCE WITH <-- LICENSURE REQUIREMENTS.

Section 606. Term and Content of License.--(a) All licenses issued by the department under this act:

(1) shall expire unless renewed 4 ONE year from the day on <-- which issued, except for a provisional or modified license;

(2) shall be on a form prescribed by the department;

(3) shall not be transferable except upon prior written approval of the department;

(4) shall be issued only to the health care provider for the health care facility or facilities named in the application; and

(5) shall specify the maximum number of beds, if any, to be used for the care of patients in the facility at any one time.

(b) The license shall at all times be posted in a conspicuous place on the provider's premises. Except in case of extreme emergency, no licensee shall permit the use of beds for inpatient use in the licensed facility in excess of the maximum number set forth in the license without first obtaining written permission from the department. The department may grant temporary use of beds without a certificate of need.

(c) The department shall require reasonable public notice of a hospital or nursing home provider's application for license reneval and any person interested as a consumer, provider or third party payor may file objections within 30 days with the department setting forth specifically the reasons therefor.

Section 607. Right to Enter and Inspect.--(a) For the purpose of determining the suitability of the applicants, the premises and the operations or the continuing conformity of the licensees to this act and to applicable State and Federal regulations, any authorized agent of the department shall, upon proper identification made to the individual in charge of the health care facility, have the right to enter, visit and inspect any provider licensed or requiring a license under this act and shall have full and free access to the records of the facility reasonably related to its purpose, to the patients and employees therein, and shall have full opportunity to interview the patients and employees, giving due regard to protection of the health and sanitary conditions, confidentiality of medical information and the patients' rights to protection against violation of their privacy involved in any such interview. No inspection made hereunder shall unduly interfere with the operation of the facility. The inspection result and any violations cited by the department shall be made public by the department within a reasonable time thereafter.

(b) The department may disclose to the public or require providers to disclose to the public any data or information as may be prescribed by regulation.

Section 608. Public Disclosure by Hospital Provider.--Every hospital provider shall disclose to the public annually the contracts or other financial arrangements between such provider

and every hospital based medical specialist connected with it who charges a fee separate and distinct from the provider's rate. The disclosure shall include gross and net proceeds actually derived from the contract or arrangement by the specialist. "Hospital based medical specialist" means any person rendering a service where there is no freedom of choice, as defined by regulation, for the patient to utilize a person offering that service who is not based in or affiliated with (except by customary staff privilege granted to numerous qualified persons in separate practices) the hospital provider.

Section 609. Refusal to Issue License; Suspension; Revocation; Notice.--(a) Whenever the department, upon reasonable complaint of any person and/or in the course of any inspection or investigation of a licensed health care facility shall learn of any violation of this act or of rules or regulations relating to licensure adopted pursuant to this act, or to Federal laws or regulations, it shall give written notice thereof to the health care provider. Such notice shall require the health care provider to take specific action to bring the health care facility into compliance with this act and the rules and regulations relating to licensure within a reasonable specified time.

(b) The department may refuse to renew a license or may revoke a license as to all or portions of a health care facility for any of the following reasons:

(1) substantial, numerous or continuing violations of provisions of this act or of the regulations for licensure issued pursuant to this act or to Federal laws or regulations;

(2) fraud or deceit in obtaining or attempting to obtain a license;

(3) lending, borrowing or using the license of another, or in any way knowingly aiding or abetting the improper granting of a license;

(4) substantial or continued incompetence, negligence or misconduct in operating the health care facility or in providing services to patients;

(5) mistreating or abusing individuals cared for by the health care facility; or

(6) the operation of a health care facility or rendering of services for which a certificate of need is required under this act by a health care provider who has not obtained the requisite certificate. ~~or whose certificate has been revoked by the department.~~ <--

(c) If the department, after examination of the application for a license or the renewal of a license or upon complaint and after such investigation as it may deem advisable, determines that there are apparent reasons for refusal of the license or a renewal as to all or a portion of the health care facility, it shall give written notice to the applicant specifying the reasons for its determination. Within 30 days of such notice, the applicant may demand a hearing which the department shall promptly provide to determine whether the license or renewal should be issued. The department may suspend or revoke a license, after due notice to the licensee of the specified charges, and a right to a hearing thereon and the department shall do so immediately in cases of imminent danger to health or safety of patients. Nothing herein contained shall impair any other enforcement powers of the department.

(d) Persons interested as consumers, providers or third party payors shall be entitled to participate in any hearings

held pursuant to this section.

Section 610. Appeal to Commonwealth Court.--If the department shall refuse a license or reneval thereof or suspend or revoke ~~or modify~~ a license, AS TO ALL OR PART OF A FACILITY <-- the applicant or licensee shall be entitled tc appeal to the Commonwealth Court from the adjudication of the department within 30 days of the service of such order upon the applicant or licensee by filing a notice of appeal. Except in cases of imminent danger to health or safety of patients, no order of the department which is appealed which would terminate the right of any person to operate a health care facility already licensed shall be effective unless the department obtains from the Commonwealth Court a decision approving the enforcement of such order or the provider fails to perfect an appeal to Commonwealth Court within 30 days. Any license previously issued shall be deemed to continue in effect pending appeal notwithstanding the expiration of its term unless otherwise determined by Commonwealth Court.

Section 611. Violation; Penalty.--(a) Any person operating a health care facility within this Commonwealth without a license required by this act, shall upon conviction thereof be sentenced to pay a fine of not more than $300, and costs of prosecution and/or to undergo imprisonment for not less than ~~30~~ TEN days nor <-- more than 30 days. Each day of operating a health care facility without a license required by this act shall constitute a separate offense.

(b) Any person, regardless of whether such person is a licensee, who has committed a violation of any of the provisions of this act pertaining to licensure or of rules and regulations related to licensure shall upon conviction thereof in a summary

proceeding be sentenced to pay a fine of not more than $300, and costs of prosecution and/or to undergo imprisonment for not more than ~~30~~ TEN days: Provided, however, That the department may <-- accept a civil forfeiture in settlement of an action. Each day the violation continues shall constitute a separate offense.

(c) These provisions shall be in addition to any other enforcement powers granted under this act.

ARTICLE VII

Uniform Accounting and Reporting~~; Rate Approval~~ <--

~~Section 701. Findings and Legislative Intent.--The General Assembly finds that many health care providers, especially hospitals, are experiencing serious financial difficulties due to a system of rate payment that is a patchwork of Federal and State Governments, profit and nonprofit insurance plans, and private individuals who are sold insured or are insured at all, and also due to fragmented State responsibility for rate regulation. It is the intent of the General Assembly that the Department of Health foster sound, efficient and dynamic health care institutions and administer this act with the goal of reducing and eventually eliminating the dysfunctions in health care financing that exist today.~~

SECTION 701. HEALTH CARE FACILITIES SUBJECT TO ARTICLE VII.--UNLESS OTHERWISE SPECIFIED, THIS ARTICLE SHALL APPLY ONLY TO THE FOLLOWING CLASSES OF HEALTH CARE FACILITIES: <--

(1) A GENERAL TUBERCULOSIS, MENTAL, CHRONIC DISEASE OR OTHER TYPE OF HOSPITAL, EXCEPT A FEDERAL FACILITY OR STATE MENTAL HOSPITAL; AND

(2) A SKILLED OR INTERMEDIATE CARE NURSING FACILITY, UNLESS CONDUCTED BY A RELIGIOUS ORGANIZATION FOR THE PURPOSE OF PROVIDING CARE EXCLUSIVELY TO CLERGYMEN OR OTHER PERSONS IN A

RELIGIOUS PROFESSION WHO ARE MEMBERS OF A RELIGIOUS DENOMINATION.

Section 702. Uniform Financial Reporting.--(a) The ~~Policy Board~~ DEPARTMENT shall by rule, after consultation WITH THE BOARD and public hearings, prescribe a uniform system of financial reporting for health care providers, specifying the information to be reported and the manner of its reporting. It shall include:

(1) a balance sheet detailing all assets, liabilities and the net worth of the institution;

(2) a statement of income and expenses for the fiscal year; and

(3) such other reports as the ~~Policy Board~~ DEPARTMENT may prescribe.

(b) Every health care provider shall file with the department the required financial reports on forms provided by the department and at specified intervals but at least annually.

(c) The ~~Policy Board~~ DEPARTMENT shall require the filing of all reports by specified dates, and may adopt regulations which assess ~~penalties~~ REASONABLE LATE FILING FEES for failure to file as required.

Section 703. Uniform System of Accounting.--(a) The ~~Policy Board~~ DEPARTMENT shall by rule, after consultation WITH THE BOARD and public hearings, prescribe a uniform system of accounting for health care providers. It shall specify accounting procedures to be applied in connection with budgets, schedules of income and expenses, assets and liabilities, allocation of costs, units of service and such subjects as the department finds appropriate.

(b) ~~Beginning with a provider's fiscal year starting on or~~

~~after January 1, 1976, every health care~~ EVERY provider shall maintain A SET OF accounts in accordance with the accounting system prescribed by the ~~Policy Board~~ DEPARTMENT BEGINNING AT A TIME DETERMINED BY THE DEPARTMENT BUT NO LATER THAN TWO YEARS FROM ENACTMENT OF THE ACT. A PROVIDER MAY MAINTAIN ANOTHER SET OF ACCOUNTS FOR ITS OWN INTERNAL MANAGEMENT PURPOSES. Accounting forms will be developed and distributed by the department.

(C) THE DEPARTMENT SHALL TAKE INTO CONSIDERATION THE PRINCIPLES OF ACCOUNTING ESTABLISHED BY THE AMERICAN INSTITUTE OF CERTIFIED PUBLIC ACCOUNTANTS, THE CHART OF ACCOUNTS ESTABLISHED BY THE AMERICAN HOSPITAL ASSOCIATION, AND ANY OTHER APPPOPRIATE STANDARDS UTILIZED BY HEALTH CARE PROVIDERS.

Section 704. Modifications in the Accounting and Reporting System.--The ~~Policy Board~~ DEPARTMENT may allow and provide for modifications in the accounting and reporting system in order to reflect differences between the various categories, sizes or types of health care providers.

SECTION 705. CLASSIFICATIONS OF PROVIDERS; COMPARISON OF REPORTS.--(A) THE DEPARTMENT SHALL, AFTER CONSULTATION WITH THE BOARD, DEVELOP CLASSIFICATIONS FOR HEALTH CARE PROVIDERS, BASED UPON SUCH CRITERIA AS SIZE, GEOGRAPHY, ECONOMIC FACTORS IN THE AREA, TYPE OF FACILITY, TEACHING PROGRAMS RELATED TO PATIENT CARE AND SCOPE OF SERVICES PROVIDED.

(B) THE DEPARTMENT SHALL REVIEW AND ANALYZE THE REPORTS TO BE MADE TO IT PURSUANT TO THIS ARTICLE AND SHALL DEVELOP A COST COMPARISON FOR EACH CLASS OF FACILITY SUBJECT TO THIS ARTICLE CONTAINING STATISTICAL NORMS WITH RESPECT TO SUCH ELEMENTS OF FINANCIAL OPERATIONS AS MAY BE DESIGNATED BY THE DEPARTMENT. THE COMPARISON SHALL INCLUDE THE COMPARISON OF EACH PROVIDER WITH EVERY OTHER PROVIDER WITHIN THE SAME CLASSIFICATION. THE

APPROPRIATE COMPARISON SHALL BE AVAILABLE TO THE GENERAL PUBLIC AT THE OFFICE OF THE DEPARTMENT AND OF EACH THIRD PARTY PAYOR AND AT EACH HEALTH CARE FACILITY.

(C) BASED UPON THE FINANCIAL REPORTS MADE TO IT AND THE COMPARISON, THE DEPARTMENT MAY IDENTIFY THOSE PROVIDERS WHOSE FINANCIAL OPERATIONS DEVIATE SIGNIFICANTLY FROM THE STATISTICAL NORMS OR FROM OTHER PROVIDERS WITHIN THE SAME CLASSIFICATION. THE DEPARTMENT MAY REQUIRE ANY HOSPITAL PROVIDER SO IDENTIFIED TO JUSTIFY THE REASONABLENESS OF THE DEVIATION AND, UPON FAILURE OF THE PROVIDER TO ADEQUATELY JUSTIFY, MAY REQUIRE THE ADOPTION AND IMPLEMENTATION OF AN APPROPRIATE COST CONTAINMENT PROGRAM.

(D) IF A HOSPITAL PROVIDER HAS FAILED TO JUSTIFY THE REASONABLENESS OF THE DEVIATION AND HAS FAILED OR REFUSED TO ADOPT AND IMPLEMENT THE COST CONTAINMENT PROGRAM REQUIRED BY THE DEPARTMENT, THE DEPARTMENT SHALL CONSIDER THE UNJUSTIFIED PORTION OF THE COST WHEN REVIEWING AND APPROVING THIRD PARTY CONTRACT RATES AND OTHER RATES PAID TO THAT PROVIDER.

SECTION 706. NURSING FACILITY COST REPORT.--EVERY SKILLED OR INTERMEDIATE CARE NURSING FACILITY SHALL ALSO HAVE AVAILABLE ON ITS PREMISES FOR PUBLIC INSPECTION A COPY OF THE FACILITY'S FINANCIAL REPORT REQUIRED BY THIS ARTICLE.

ARTICLE VIII

RATE APPROVAL

SECTION 801. HEALTH CARE FACILITIES SUBJECT TO ARTICLE VIII.--THIS ARTICLE SHALL APPLY ONLY TO GENERAL, TUBERCULOSIS, MENTAL, CHRONIC DISEASE OR OTHER TYPE OF HOSPITAL, EXCEPT A FEDERAL FACILITY OR STATE MENTAL HOSPITAL.

Section ~~705~~ 802. Rate Review; Timetable.--~~The rates to be paid to health care providers shall become subject to review by the department according to the following timetable:~~ <--

~~(a) Rates Paid by Third Parties.--Beginning January 1, 1976, contracts~~ (A) CONTRACTS AND CONTRACT RATES between ~~health care~~ providers and third party CONTRACT payors for the rendering of health care services~~, including the rates to be paid,~~ shall require the approval of the department PURSUANT TO SECTION 803 BEGINNING AT A TIME DETERMINED BY THE DEPARTMENT BUT NO LATER THAN TWO YEARS FROM THE ENACTMENT OF THE ACT. <--

~~For contracts between hospital providers and any hospital plan corporation, as defined in the act of December 15, 1972 (P.L.1062, No.274), requiring the approval of the Insurance Commissioner, the secretary shall approve the rates to be charged in the contract and the terms and conditions of rate payment and the Insurance Commissioner shall approve all other provisions not related to rates.~~ <--

~~(b) Nursing Home Rates.--Beginning January 1, 1977, all rates to be paid to nursing homes shall require the approval of the department.~~

~~(c) Other Rates.--Beginning January 1, 1978, all other rates~~ (B) ALL OTHER RATES to be paid to ~~health care~~ providers ~~not already subject to review~~ shall require the approval of the department PURSUANT TO SECTION 804 BEGINNING AT A TIME DETERMINED BY THE DEPARTMENT BUT NO LATER THAN TWO YEARS FROM THE ENACTMENT OF THE ACT. <--

~~(d) Discretionary Implementation.--Implementation of rate approval for hospital providers and skilled or intermediate care nursing facilities shall conform to the schedule prescribed by this section. Implementation of rate approval for all other classes of health care facilities shall be at such times and according to such schedules as the board determines, but in no~~ <--

~~event shall implementation precede the schedule prescribed for hospital providers.~~

~~Section 706. Standards.--(a) Rates, in the aggregate, when combined with available income from other sources, shall be reasonably related to the provider's total financial requirement (as defined by the board) necessary for the efficient production of services.~~

~~Such rates for for-profit health care providers shall allow a fair rate of return on the fair value of the investment.~~

~~Rates for nongovernmental health care providers shall incorporate incentives for increasing efficiency and/or improving services.~~

~~(b) In approving rates to be paid to health care providers, the department shall take into consideration the elements of allowable cost established by the Policy Board, the provider's total financial requirement, geographical differentials in the elements of cost considered, economic factors in the areas in which the provider is located, patient mix, and costs of providers of comparable size and services.~~

~~(c) The Policy Board shall take into consideration the principles of accounting established by the American Institute of Public Accountants, the chart of accounts established by the American Hospital Association, and any other appropriate standards utilized by health care providers.~~

SECTION 803. THIRD PARTY CONTRACT PAYOR.--(A) A THIRD PARTY <--
PAYOR SHALL BE DENOMINATED A THIRD PARTY CONTRACT PAYOR TO BE
REGULATED UNDER THIS SECTION IF IT SHALL AS A MATTER OF GENERAL
PRACTICE:

(1) NEGOTIATE AND ENTER INTO CONTRACTS WITH HOSPITAL
PROVIDERS FOR THE RENDITION OF HEALTH CARE SERVICES;

(2) ENTER INTO COST CONTROL ARRANGEMENTS WITH HOSPITAL
PROVIDERS;

(3) PROVIDE FOR REASONABLE OPEN ENROLLMENT PERIODS ON AN
ANNUAL OR SEMI-ANNUAL BASIS, WHEREBY INDIVIDUALS ARE ACCEPTED
FOR COMPREHENSIVE HEALTH CARE EXPENSE COVERAGE AND SERVICE
BENEFITS WITHOUT REGARD TO HEALTH;

(4) PROVIDE CONVERSION PRIVILEGES ON ALL GROUP CONTRACTS,
WHEREBY INDIVIDUALS NO LONGER ELIGIBLE FOR GROUP COVERAGE MAY
OBTAIN INDIVIDUAL COMPREHENSIVE HEALTH CARE EXPENSE COVERAGE AND
SERVICE BENEFITS WITHOUT REGARD TO HEALTH;

(5) PROVIDE FOR COVERAGE BY WAY OF SERVICE BENEFITS RATHER
THAN FIXED DOLLAR AMOUNT BENEFITS, IN ORDER TO PROVIDE
COMPREHENSIVE PROTECTION WHICH RESPONDS TO CHANGING MEDICAL
PROCEDURES AND TECHNOLOGY;

(6) PROVIDE GROUP COVERAGE WITH SERVICE BENEFITS FOR GROUPS
AS SMALL AS FIVE INDIVIDUALS;

(7) PROVIDE HEALTH CARE SERVICE BENEFITS ON A NON-GROUP
BASIS AT A REASONABLE EXPENSE RATIO;

(8) PROVIDE FOR CONSUMER PARTICIPATION THROUGH THE THIRD
PARTY CONTRACT PAYOR'S GOVERNING BOARD; AND

(9) ELIMINATE ANY CONTRACT OR COVERAGE WHICH PROVIDES
BENEFITS SO LIMITED AS TO BE OF NO SUBSTANTIAL ECONOMIC VALUE TO
THE POLICYHOLDER OR SUBSCRIBER, OR PROVIDES BENEFITS THAT ARE
UNREASONABLE IN RELATION TO THE PREMIUM CHARGED.

(B) THE INSURANCE COMMISSIONER SHALL CERTIFY ANNUALLY TO THE
SECRETARY THE FINDINGS OF THE INSURANCE DEPARTMENT WITHIN ITS
PURVIEW REGARDING COMPLIANCE WITH THE REQUIREMENTS FOR
ELIGIBILITY OF THIRD PARTY CONTRACT PAYORS.

(C) CONTRACTS BETWEEN PROVIDERS AND THIRD PARTY CONTRACT
PAYORS FOR THE PROVISION OF HEALTH CARE SERVICES, INCLUDING THE

RATES TO BE PAID, SHALL REQUIRE THE APPROVAL OF THE DEPARTMENT. FOLLOWING NEGOTIATIONS WITH HOSPITAL PROVIDERS TO BE AFFECTED THEREBY, CONDUCTED IN ACCORDANCE WITH STANDARDS ESTABLISHED BY THE DEPARTMENT, A THIRD PARTY CONTRACT PAYOR SHALL FILE WITH THE DEPARTMENT AN APPLICATION FOR APPROVAL OF ANY PROPOSED CONTRACT OR ANY MODIFICATIONS TO AN EXISTING CONTRACT. THE APPLICATION SHALL DESIGNATE THE PROVIDERS TO BE AFFECTED, BY NAME OR BY GEOGRAPHICAL DESIGNATION. THE DEPARTMENT SHALL PUBLISH NOTICE OF THE FILING OF THE APPLICATION AND SHALL SET A HEARING FOR A TIME NOT MORE THAN 30 DAYS FROM DATE OF PUBLICATION. A THIRD PARTY CONTRACT PAYOR SHALL HAVE THE RIGHT TO A HEARING CONDUCTED IN ACCORDANCE WITH THE PROVISIONS OF THE ACT OF JUNE 4, 1945 (P.L.1388, NO.442), KNOWN AS THE "ADMINISTRATIVE AGENCY LAW." WITHIN 60 DAYS AFTER RECEIPT OF THE FINDINGS AND CONCLUSIONS OF THE HEARING OFFICER, THE DEPARTMENT SHALL ISSUE AN ORDER APPROVING, DENYING OR APPROVING IN PART THE APPLICATION. IF THE DEPARTMENT TAKES NO ACTION WITHIN 60 DAYS AFTER SUCH RECEIPT, THE APPLICATION SHALL BE DEEMED APPROVED. ORDERS OF THE DEPARTMENT UPON AN APPLICATION FOR APPROVAL SHALL BE SUBJECT TO JUDICIAL REVIEW PURSUANT TO SECTION 405. UPON APPROVAL, ALL PROVIDERS DESIGNATED IN THE FILING OF THE APPLICATION SHALL BE BOUND BY THE TERMS THEREOF AS APPROVED BY THE DEPARTMENT. CONTRACT RATES SHALL, WITHIN THE TERMS ESTABLISHED BY THE CONTRACT, REQUIRE THE ANNUAL APPROVAL OF THE DEPARTMENT.

PROVISIONS IN TITLE 40 PA.C.S. § 6101, WHICH REQUIRE CONTRACTS BETWEEN A HOSPITAL PROVIDER AND ANY HOSPITAL PLAN CORPORATION TO BE APPROVED BY THE INSURANCE COMMISSIONER, ARE HEREBY REPEALED TO THE EXTENT OF THEIR INCONSISTENCY WITH THIS ACT. THE DEPARTMENT SHALL CERTIFY TO THE INSURANCE COMMISSIONER THE CONTRACTS AND CONTRACT RATES IT HAS APPROVED AND THE

INSURANCE COMMISSIONER SHALL ACCEPT SUCH CONTRACTS AND CONTRACT RATES IN CONNECTION WITH ANY PROCEEDINGS BEFORE THE INSURANCE COMMISSIONER RELATING TO RATES TO BE CHARGED TO, OR OTHER CONTRACT PROVISIONS WITH, SUBSCRIBERS OF THE HOSPITAL PLAN CORPORATION.

(D) RATES CONTAINED IN CONTRACTS SHALL BE REASONABLY RELATED TO THE COSTS (AS DEFINED BY THE DEPARTMENT) PROJECTED OR INCURRED BY PROVIDERS FOR THE EFFICIENT PRODUCTION OF SERVICES. THE DEPARTMENT SHALL TAKE INTO CONSIDERATION THE ELEMENTS OF ALLOWABLE COST, THE NEED FOR INCENTIVES TO IMPROVE SERVICES AND INSTITUTE ECONOMIES, GEOGRAPHICAL DIFFERENTIALS IN THE ELEMENTS OF COST CONSIDERED, ECONOMIC FACTORS IN THE AREAS IN WHICH THE PROVIDER IS LOCATED, PATIENT MIX, AND COSTS OF PROVIDERS OF COMPARABLE SIZE AND SERVICES. THE DEPARTMENT SHALL ALSO TAKE INTO CONSIDERATION THE ECONOMIES AND IMPROVEMENTS IN SERVICE TO BE ANTICIPATED FROM THE OPERATION OF JOINT CENTRAL SERVICES OR USE OF FACILITIES OR SERVICES WHICH MAY SERVE AS ALTERNATIVES OR SUBSTITUTES FOR THE WHOLE OR ANY PART OF ANY SERVICES, INCLUDING, BUT NOT LIMITED TO, OBSTETRICAL, PEDIATRIC, LABORATORY, RADIOLOGY, PHARMACY, LAUNDRY, PURCHASING, PRE-ADMISSION, NURSING HOME, AMBULATORY OR HOME CARE SERVICES. A THIRD PARTY CONTRACT PAYOR MAY EXCLUDE THOSE COSTS FOR RESEARCH AND EDUCATION DETERMINED TO BE NOT DIRECTLY RELATED TO PATIENT CARE AND COSTS OF PROVIDING HEALTH CARE SERVICES TO THOSE NOT RECEIVING BENEFITS THROUGH A THIRD PARTY CONTRACT PAYOR.

(E) IN ORDER TO NEGOTIATE AND ENTER INTO CONTRACTS WITH HEALTH CARE PROVIDERS, A THIRD PARTY CONTRACT PAYOR MAY CONDUCT INSPECTIONS, INVESTIGATIONS, AUDITS OR OTHER REVIEWS OF FINANCIAL AND OPERATIONAL REPORTS ON MATTERS RELATING TO HEALTH CARE FACILITIES AND SERVICES OF PROVIDERS.

SECTION 804. OTHER RATES.--(A) RATES PAID TO PROVIDERS WHICH ARE NOT APPROVED PURSUANT TO SECTION 802 SHALL REQUIRE THE APPROVAL OF THE DEPARTMENT.

(B) RATES, IN THE AGGREGATE, WHEN COMBINED WITH AVAILABLE INCOME FROM FEDERAL REIMBURSEMENTS, SHALL BE REASONABLY RELATED TO THE PROVIDER'S REASONABLE FINANCIAL NEEDS, AS DEFINED BY THE DEPARTMENT, NECESSARY FOR THE EFFICIENT PRODUCTION OF SERVICES. THE DEPARTMENT SHALL TAKE INTO CONSIDERATION THE ELEMENTS OF ALLOWABLE COST, THE NEED FOR INCENTIVES TO IMPROVE SERVICES AND INSTITUTE ECONOMIES, GEOGRAPHICAL DIFFERENTIALS IN THE ELEMENTS OF COST CONSIDERED, ECONOMIC FACTORS IN THE AREAS IN WHICH THE PROVIDER IS LOCATED, PATIENT MIX, AND COSTS OF PROVIDERS OF COMPARABLE SIZE AND SERVICES. THE DEPARTMENT SHALL ALSO TAKE INTO CONSIDERATION THE ECONOMIES AND IMPROVEMENTS IN SERVICE TO BE ANTICIPATED FROM THE CONSOLIDATION OF SERVICES OR USE OF ALTERNATIVES OR SUBSTITUTE SERVICES. RATES FOR FOR-PROFIT HOSPITAL PROVIDERS SHALL ALLOW A FAIR RATE OF RETURN ON THE FAIR VALUE OF THE INVESTMENT.

RATES FOR NONGOVERNMENTAL HEALTH CARE PROVIDERS SHALL INCORPORATE INCENTIVES FOR INCREASING EFFICIENCY AND/OR IMPROVING SERVICES.

(C) IN ORDER TO FACILITATE RATE APPROVAL, THE DEPARTMENT MAY ESTABLISH PERMISSIBLE MAXIMUM CHANGES IN RATES FOR PROVIDERS. IF THE RATES, AS FILED, FALL WITHIN THE MAXIMUM, THE RATE SHALL BE DEEMED TO BE APPROVED.

(d) The department may promote and approve alternative methods of rate determination or payment of an experimental or innovative nature.

Section ~~307~~ 805. Procedures.--(a) The ~~Policy Board~~ DEPARTMENT shall by rule, after consultation and public <--

hearings, establish procedures for the filing, review and determination of rates in a fair and expeditious manner AND FOR PROPER COORDINATION WITH THE APPROVAL OF CONTRACT RATES. <--

(B) RATES PAID BY THE COMMONWEALTH AS PAYMENTS TO PROVIDERS PURSUANT TO TITLE XIX OF THE FEDERAL SOCIAL SECURITY ACT AND RATES PAID TO A PROVIDER PURSUANT TO ANY AGREEMENT FOR THE PURCHASE OF SERVICES ON A GROUP BASIS SHALL BE REVIEWED AND IN ACCORDANCE WITH PROCEDURES ESTABLISHED BY THE DEPARTMENT.

~~(b)~~ (C) The department may require such information, including the provider's proposed budget, to be submitted to the department in support of a provider's rates OR CONTRACT RATES as it deems necessary. If the department by rule limits the expenditure of funds from capital accounts, the proposed budget may be used to verify such limitation upon audit. <--

~~(c)~~ (D) The department shall review rates within a ~~reasonable~~ DEFINITE period of time~~, as defined by the Policy Board, after the deadline for submission.~~ PRESCRIBED BY DEPARTMENTAL REGULATION. Rates not acted upon by the department within the prescribed time ~~limit~~ PERIOD shall be deemed approved automatically. <--

Section ~~308~~ 806. Opportunity to Be Heard.--Prior to approval of any rate OR CONTRACT RATE by the department the provider and any person interested as a consumer or third party payor shall be entitled to an opportunity to be heard on the reasonableness of such rate. <--

Section ~~309~~ 807. Rate Exceptions; Procedures.--(a) Any provider or any person interested as a consumer or third party payor may request an exception from the rate OR CONTRACT RATE approved by the department for good cause shown by petition to the ~~board.~~ SECRETARY. <--

(b) The ~~board~~ SECRETARY may ~~provide for~~ DIRECT the taking of evidence upon the petition~~, either~~ by appointment of an impartial hearing examiner. ~~or by designation of a board member or panel of members, by the chairman.~~ Such examiner~~, member or members~~ shall be authorized to administer oaths, compel the attendance of witnesses and the production of records or other information, and examine witnesses. Other parties interested as providers, consumers or third party payors may also present evidence and participate in the hearing. After the hearing, findings of fact, conclusions and recommendations shall be presented to the ~~board.~~ SECRETRAY.

(c) Within 60 days of the petition for an exception, unless extended by the ~~board~~ SECRETARY with the consent of the provider for no more than 60 additional days, the ~~board~~ SECRETARY shall either deny the petition or grant the petition in whole or in part and approve a new rate.

(d) Judicial appeals may be taken pursuant to section 405. ~~of this act.~~

SECTION 808. DEMONSTRATION FUNDS.--THE DEPARTMENT IS AUTHORIZED TO APPLY FOR DEMONSTRATION GRANTS FROM THE FEDERAL GOVERNMENT FOR IMPLEMENTATION OF RATE REVIEW SYSTEMS.

Section ~~710~~ 809. Public Inspection.--A ~~health care~~ provider's schedule of rates in force and a schedule of rates, if any, submitted to the department for its approval, with the required supporting information, shall be available for inspection by the public during business hours in the offices of the department, the provider and any contracting party.

Section ~~711~~ 810. Compliance.--No ~~health care~~ provider shall charge for services at rates other than those approved by the department. NO THIRD PARTY PAYOR SHALL MAKE PAYMENTS TO A

PROVIDER AT TERMS OTHER THAN THOSE APPROVED BY THE DEPARTMENT.

When a provider charges a rate higher than that approved by the department, the department may order compensatory adjustments in rates for subsequent years.

Section ~~712~~ 811. Penalty.--Any ~~health care~~ provider or officer, director or agent thereof who knowingly fails to comply with the requirements of this article shall, upon conviction thereof in a summary proceeding, be sentenced to pay a fine of not more than $300 and costs of prosecution, and/or to undergo imprisonment for not less than ~~40~~ TEN days and not more than 30 days: Provided, however, That the department may accept a civil forfeiture in settlement of an action. Each day of noncompliance shall constitute a separate offense.

SECTION 812. NOTHING IN THIS ARTICLE SHALL ABROGATE, ALTER, AFFECT OR DELAY THE IMPLEMENTATION OF A COLLECTIVE BARGAINING AGREEMENT.

ARTICLE ~~VII~~ IX

Proceedings Against Unlicensed Health Care Providers and Violators

Section ~~801~~ 901. Actions Against Unlicensed Health Care Providers.--Whenever a license is required by this act for the establishment, operating or conduct of a health care facility, the department may maintain an action in the name of the Commonwealth for an injunction or other process restraining or prohibiting any person from establishing, conducting or operating any unlicensed health care facility.

Section ~~802~~ 902. Actions Against Violations of Law and Rules and Regulations.--(A) Whenever any person, regardless of whether such person is a licensee, has violated any of the provisions of this act ~~pertaining to licensure~~ or the regulations issued

pursuant thereto, the department may maintain an action in the name of the Commonwealth for an injunction or other process restraining or prohibiting such person from engaging in such activity.

(B) ANY PERSON, REGARDLESS OF WHETHER SUCH PERSON IS A LICENSEE, WHO HAS COMMITTED A VIOLATION OF ANY OF THE PROVISIONS OF THIS ACT OR OF RULES AND REGULATIONS ISSUED PURSUANT THERETO SHALL UPON CONVICTION THEREOF IN A SUMMARY PROCEEDING BE SENTENCED TO PAY A FINE OF NOT MORE THAN $300, AND COSTS OF PROSECUTION AND/OR TO UNDERGO IMPRISONMENT FOR NOT MORE THAN TEN DAYS: PROVIDED, HOWEVER, THAT THE DEPARTMENT MAY ACCEPT A CIVIL FORFEITURE IN SETTLEMENT OF AN ACTION. EACH DAY THE VIOLATION CONTINUES SHALL CONSTITUTE A SEPARATE OFFENSE. <--

Section ~~803~~ 903. Injunction or Restraining Order When Appeal is Pending.--Whenever the department shall have refused to grant or renew a license, or shall have suspended or revoked a license required by this act to operate or conduct a health care facility, or shall have ordered the person to refrain from conduct violating the rules and regulations of the department and the person deeming himself aggrieved by such refusal or suspension or revocation or order shall have appealed from the action of the department, the Commonwealth Court may, during pendency of such appeal, issue a restraining order or injunction upon a showing that the continued operation of the health care facility adversely affects the well-being ~~and safety~~, SAFETY OR INTERESTS of the patients of the health care facility, or the court may authorize continued operation of the facility or make such other order pending final disposition of the case as justice and equity require. <--

Section ~~804~~ 904. Injunction or Restraining Order When No <--

Appeal is Pending.--Should a person, who is refused a license or the renewal of a license to operate or conduct a health care facility, or whose license to operate or conduct a health care facility is suspended or revoked, fail to appeal or should such appeal be decided finally favorably to the department, then the court shall issue a permanent injunction upon proof that the person is operating or conducting a health care facility without a license as required by this act.

Section ~~805~~ 905. Bonds and Costs.--No bond shall be required of the department in any legal action. <--

Section ~~806~~ 906. Remedies Supplementary.--The provisions of this article are supplementary to any other legal rights created in this act or any other act available for the enforcement of provisions of this act and rules and regulations promulgated thereunder. <--

ARTICLE ~~XI~~ X <--

General Provisions

Section ~~901~~ 1001. Licenses and Certificates for Existing Facilities.--All health care providers licensed or approved on the effective date of this act to conduct, maintain or operate a health care facility or who are operating such facility which has been licensed or approved, shall be issued a license immediately upon application and all such providers WHO ARE SUBJECT TO THE CERTIFICATE OF NEED PROVISIONS OF THE ACT shall be issued forthwith a certificate of need by the department for all buildings, real property and equipment owned, leased or being operated or under contract for construction, purchase or lease and for all services being rendered by the licensed or approved providers on the effective date of this act. To facilitate administration of this act, the department may <--

initially grant some licenses ~~and certificates of need~~ for <--
periods less than the prescribed term and may permit the running
of licenses or approvals currently granted to providers, as may
be required to stagger the dates for renewal.

Section ~~903~~ 1002. Administration of the Act.--(a) No health <--
care provider shall be required by any provisions of this act or
rules and regulations promulgated thereunder to provide
facilities or render services contrary to the stated religious
or moral beliefs of the provider, nor shall any applicant be
denied a license or a certificate of need or the right to apply
for or receive public funds on the grounds he will not provide
the facilities or render the services for such reasons.

(b) Except as otherwise provided by law, no provider shall
discriminate in the operation of a health care facility on the
basis of race, creed, sex or national origin.

(c) Consumers shall have freedom of choice in the selection
of health care facilities and nothing in this act or any rules
and regulations promulgated pursuant thereto shall be
interpreted to require any consumer to use any particular health
care facility or to be denied the use of any particular health
care facility; but such freedom shall not carry with it the
right to be attended therein by the consumer's personal
physician if the physician is not authorized to practice
therein.

(d) In carrying out the provisions of this act and other
statutes of this Commonwealth relating to health care
facilities, the department and ~~the~~ OTHER departments and ~~other~~ <--
agencies ~~and officials~~ of State and local governments shall make <--
every reasonable effort to prevent duplication of inspections
and examinations.

(e) The department shall not administer this act in a way
that will stifle innovation or experimentation in health care
and health care facilities or that will discourage contributions
of private funds and services to health care facilities.

Section ~~903~~ 1003. Appropriation.--The sum of $1,500,000, or <--
as much thereof as may be necessary, is hereby appropriated to
the department for the purpose of the administration and
enforcement of this act.

~~Section 904. Transfer of Powers.--The Advisory Health Board~~ <--
~~is abolished and its powers, duties and functions are hereby~~
~~transferred to the Health Care Policy Board.~~

~~Section 905~~ SECTION 1004. Repeals.--(a) The provisions of <--
Articles IX and X, act of June 13, 1967 (P.L.31, No.21), known
as the "Public Welfare Code" are repealed in so far as they
relate to health care facilities. HOWEVER, ON THE EFFECTIVE DATE <--
OF THE ACT ANY RULES OR REGULATIONS ISSUED UNDER THESE
PROVISIONS WILL REMAIN IN EFFECT UNTIL SUPERSEDED BY ORDER OF
THE DEPARTMENT.

(B) TO THE EXTENT THAT ANY PROVISIONS OF THE ACT IS IN
CONFLICT WITH THE PROVISIONS OF THE ACT OF DECEMBER 29, 1972
(P.L.1701, NO.364), KNOWN AS THE "VOLUNTARY NONPROFIT HEALTH
SERVICE ACT OF 1972," THE PROVISIONS OF THE LATTER ACT SHALL BE
CONTROLLING.

~~(b)~~ (C) All acts and parts of acts are hereby repealed in so <--
far as inconsistent with the provisions of this act.

Section ~~906~~ 1005. Effective Date.--This act shall take <--
effect ~~immediately~~ IN 90 DAYS. <--

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 427 Session of 1971

INTRODUCED BY OESTERLING, MESSINGER, CIANFRANI, AMMERMAN, MELLOW, MAZZEI, STAPLETON AND REIBMAN, MARCH 29, 1971

REFERRED TO PUBLIC HEALTH AND WELFARE, MARCH 29, 1971

AN ACT

Creating the Pennsylvania Hospital Control Commission as an independent administrative commission; defining the powers and duties of such commission; regulating the various rates charged by all hospitals within the Commonwealth; controlling the construction and utilization of such hospitals; regulating the premium rates for hospitalization insurance within the Commonwealth; providing procedures for the enforcement of the provisions of the act and providing penalties.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Short Title.--This act shall be known and may be cited as the "Pennsylvania Hospital Control Commission Act."

Section 2. Legislative Findings.--Rising hospital costs are a matter of vital concern to the people of this State. The relentless increases in such costs encountered in recent years pose dangers to all purchasers of hospital services as well as hospitals themselves. The cost of hospital care is increasing faster than any other item in the consumer price index. The individual consumer has been spending a larger share of his earnings on hospital care and the average cost per hospital stay

continues to rise disproportionately to the increase in per capita income.

In part, hospital cost increases result from necessary improvement in wages and fringe benefits for hospital workers, improvements in equipment and service, and enhanced capability to save lives. However, while improved quality of services, increased use of facilities and rising prices are factors in accelerating hospital costs, there are nevertheless wide unexplained variations in the cost of the same services rendered by hospitals in the same area. Continued pressure for unnecessary duplication of facilities and heavy standby commitments for under-utilized services in one area contrast with long waiting lists for admission to facilities in other areas. Inefficient management and resultant higher costs need to be eliminated lest they threaten access to care and emergency services for many of our citizens.

The Legislature therefore finds and declares that it is essential that an effective cost control program be established which will both enable and motivate hospitals to control their spiraling costs. It is the intent of this act to provide for uniform measures on a Statewide basis to control hospital costs without the sacrifice of quality of service.

Section 3. Definitions.--As used in this act--

"Commission" means the Pennsylvania Hospital Control Commission.

"Hospital" means any premises, other than a mental health establishment operated for profit, or being a nonprofit institution, having an organized medical staff and providing equipment and services primarily for inpatient care for two or more individuals who require definitive diagnosis and/or

treatment for illness, injury or other disability or during or after pregnancy, and which also regularly makes available at least clinical laboratory services, diagnostic X-ray services and definitive clinical treatment services. The term shall include such premises providing either diagnosis or treatment, or both, for specific illnesses or conditions.

Section 4. Pennsylvania Hospital Control Commission.--(a) An independent administrative commission to be known as the "Pennsylvania Hospital Control Commission" is hereby created. The commission shall consist of three members to be appointed by the Governor by and with the advice and consent of two-thirds of all members of the Senate. Of the original members, one shall be appointed for a term of two years, one for a term of four years, and one for a term of six years from the date of his appointment and until his successor shall have been appointed and qualified. Thereafter, all appointments shall be for terms of six years or until successors are appointed and qualified.

(b) Each member of the commission at the time of his appointment and qualification shall be a citizen of the United States and a resident of the Commonwealth of Pennsylvania and shall have been a qualified elector in the Commonwealth for a period of at least one year next preceding his appointment. No member of the commission during his period of service as such shall hold any other office under the laws of this Commonwealth or of the United States.

(c) The commission shall elect one of its members as chairman. The chairman shall, when present, preside at all meetings, and in his absence a member designated by the chairman shall preside. Two members of the commission shall constitute a quorum, and any action or order of the commission shall require

the approval of at least two members.

(d) The commission may appoint an executive director and hire or engage such other employes or consultants as may be deemed necessary to carry out the powers and duties imposed on the commission by this act. Such executive director and such other employes or consultants shall perform such duties, not contrary to law, as the commission shall prescribe and shall receive such compensation as the commission shall determine.

(e) Annual salaries of the members of the commission shall be payable in equal installments every other week, as follows:

To the chairman of the commission..... $19,000

To the members of the commission..... 18,000

(f) Except as otherwise expressly provided by law, the commission shall be subject to all the provisions of the act of April 9, 1929 (P. L. 177), known as "The Administrative Code of 1929," as amended, which apply generally to independent administrative boards and commissions.

Section 5. Duties of Hospitals; Operating Certificates.--(a) It shall be the duty of every hospital within the Commonwealth, as herein defined:

(1) To submit to the commission for approval the schedules of rates, payments, reimbursements, grants and charges for hospital and health related services rendered by such hospital;

(2) To submit to the commission for approval any plans for new construction or expansion of existing facilities at any such hospital;

(3) To submit to the commission for approval a plan for the utilization of all facilities at any such hospital.

(b) Every hospital within the Commonwealth, as herein defined, shall be subject to the provisions of this act and must

obtain from the commission an operating certificate, the possession of which shall be necessary for the rendering of any service by any such hospital.

Section 6. Duties of Certain Insurance Companies.--(a) Any insurance company which is subject to the jurisdiction of the Insurance Commissioner of the Commonwealth which issues policies of insurance covering the costs of hospitalization shall, in addition to any similar requirements by any other law, file with the commission a copy of the classification of risks and the premium rates pertaining to such insurance.

(b) No policy of insurance covering the costs of hospitalization shall be issued or delivered by any insurance company, which is subject to the jurisdiction of the Insurance Commissioner of the Commonwealth, to any person in this Commonwealth until the provisions of subsections (a) and (c) of this section are complied with.

(c) In addition to any other approval which may be required by law, the classification of risks and the premium rates of any such policies of insurance covering costs of hospitalization must be approved by the commission.

Section 7. Powers and Duties of the Commission.--The commission shall have the power and its duty shall be:

(1) To grant operating licenses to hospitals which comply with the provisions of this act;

(2) To approve the schedules of rates, payments, reimbursements, grants and other charges for hospital and health related services rendered by each hospital;

(3) To approve the plans for new construction or expansion of existing facilities at any hospital;

(4) To approve the plans for the utilization of facilities

at any hospital;

(5) To approve the classification of risks and premium rates of any policies of insurance covering costs of hospitalization issued by insurance companies which are subject to the jurisdiction of the Insurance Commissioner of the Commonwealth; and

(6) To promulgate such rules and regulations, not inconsistent with law, necessary for the proper administration of the provisions of this act.

Section 8. Procedure Before the Commission.--(a) The commission may on its own motion or shall upon the petition of any hospital or insurance company within the scope of this act, after ten days' written notice, conduct a hearing on any matter which the commission has the power and duty to grant its approval.

(b) All hearings before the commission shall be public, and shall be conducted in accordance with such regulations as the commission may prescribe. A full and complete record shall be kept of all proceedings had before the commission on any formal hearing, and all testimony shall be taken down by a reporter appointed by the commission, and the parties shall be entitled to be heard in person or by attorney, and to introduce evidence.

(c) The commission shall have the power, in any part of the Commonwealth, to subpoena witnesses, to administer oaths, to examine witnesses, or to take such testimony, or compel the production of such books, records, papers, and documents as it may deem necessary or proper in, and pertinent to, any proceeding, investigation, or hearing, held or had by it, and to do all necessary and proper things and acts in the lawful exercise of its powers or the performance of its duties. The

fees for serving a subpoena shall be the same as those paid sheriffs for similar services.

(d) The commission may, on its own motion and whenever it may be necessary in the performance of its duties, investigate and examine any hospital or insurance company subject to this act. In conducting such investigations the commission may proceed, either with or without a hearing, as it may deem best, but it shall make no order without affording the parties affected thereby a hearing.

(e) After the conclusion of the hearing, the commission shall make and file its findings and order with its opinion, if any. Its findings shall be in sufficient detail to enable the court on appeal, to determine the controverted question presented by the proceeding, and whether proper weight was given to the evidence. A copy of such order, certified under the seal of the commission, shall be served by registered mail upon the hospital or insurance company against whom it runs, or its attorney, and notice thereof shall be given to the other parties to the proceedings or their attorney. Such order shall take effect and become operative as designated therein, and shall continue in force either for a period which may be designated therein, or until changed or revoked by the commission. If an order cannot, in the judgment of the commission, be complied with within the time designated therein, the commission may grant and prescribe such additional time as, in its judgment, is reasonably necessary to comply with the order, and may, on application and for good cause shown, extend the time for compliance fixed in its order.

(f) The commission may, at any time, after notice and after opportunity to be heard, rescind or amend any order made by it.

Any order rescinding or amending a prior order shall, when served upon the hospital or insurance company affected, and after notice thereof is given to the other parties to the proceedings, have the same effect as is herein provided for original orders; but no such order shall affect the legality or validity of any acts done by such hospital or insurance company before service by registered mail upon such person, corporation, or municipal corporation of the notice of such change.

Section 9. Appeals to Courts.--(a) Within thirty days after the service of any order by the commission, any party to the proceedings affected thereby may appeal therefrom to the Superior Court. Such court is hereby clothed with exclusive jurisdiction throughout the Commonwealth for the purpose of hearing and determining any and all such appeals. If an appeal be taken to any court other than the Superior Court, the case shall proceed in accordance with the practice and procedure made and provided in such cases.

(b) All appeals to the Superior Court shall be by petition, setting forth specifically and concisely the error or errors assigned to the order of the commission, which petition shall be accompanied by a copy of the order appealed from, and shall also be accompanied by affidavit of the appellant, or of the agent or attorney of such appellant, that the appeal is not taken for the purpose of delay, but because the appellant verily believes that injustice has been done. Each error relied on must be specified particularly and set forth in a separate numbered paragraph of the petition.

Section 10. Penalties.--Any person, whether or not an officer, agent, or employe, of any hospital or insurance company, who or which shall knowingly fail, omit, neglect or

refuse to obey, observe, and comply with any regulation or final order, direction, or requirement of the commission, or any order of the commission prescribing temporary rates in any rate proceeding, or any final order or decree of any court, or who shall knowingly procure, aid, or abet any such violation, omission, failure, neglect, or refusal, shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay the costs of prosecution and a fine of not more than five hundred dollars ($500), or undergo imprisonment for not less than one month nor more than one year, or both, at the discretion of the court; and upon conviction of any subsequent offense shall be sentenced to pay the costs of prosecution and a fine of not more than one thousand dollars ($1,000), or undergo imprisonment for not less than three months nor more than two years, or both, at the discretion of the court.

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 600 Session of 1971

INTRODUCED BY MESSRS. GELFAND, SCHMITT, BRUNNER, RAPPAPORT AND GREENFIELD, MARCH 30, 1971

REFERRED TO COMMITTEE ON CONSUMER PROTECTION, MARCH 30, 1971

AN ACT

Creating the Pennsylvania Health Agency as an independent administrative agency; defining the powers and duties of such agency; regulating the delivery, furnishing, planning, providing and sale of all health and medical services and products within the Commonwealth and regulating the construction and purchase of capital facilities used therein; providing procedures for the enforcement of the provisions of the act; making an appropriation and providing penalties.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Short Title.--This act shall be known and may be cited as the "Pennsylvania Health Agency Act."

Section 2. Definitions.--As used in this act--

(1) "Agency" means the Pennsylvania Health Agency.

(2) "Control board" means one of the five designated boards of the agency.

(3) "Hospital" means any premises, other than a mental health establishment, operated for profit, or being a nonprofit institution, having an organized medical staff and providing equipment and services primarily for inpatient care for two or more individuals who require definitive diagnosis and/or

treatment for illness, injury or other disability or during or after pregnancy, and which also regularly makes available at least clinical laboratory services, diagnostic X-ray services and definitive clinical treatment services. The term shall include such premises providing either diagnosis or treatment, or both, for specific illnesses or conditions.

(4) "Health care facilities" means any premises not included or specifically excluded in the definition of "hospital" and used in the performance of health care or services except the office of an individual practicing physician shall not be included.

(5) "Health care personnel" means all persons, whether professional or nonprofessional, involved in any manner in rendering health care or services.

Section 3. Pennsylvania Health Agency.--(a) An independent administrative agency to be known as the "Pennsylvania Health Agency" is hereby created. The agency shall be divided into five control boards, as follows:

(1) The Hospital Control Board;

(2) The Health Services Control Board;

(3) The Health Profession Control Board;

(4) The Health Facilities Control Board; and

(5) The Health Planning Board.

(b) The agency shall consist of fifteen members, three of whom shall also serve as members of the Hospital Control Board, three of whom shall also serve on the Health Services Board, three of whom shall also serve on the Health Profession Control Board, three of whom shall also serve on the Health Facilities Control Board, and three of whom shall serve on the Health Planning Board. Each member shall be appointed by the Governor,

by and with the advice and consent of two-thirds of all the members of the Senate, and shall, except as hereinafter provided, hold office for terms of four years each and until his successor has been appointed and qualified.

(c) Of the members first appointed, four shall be appointed for a term of one year, four shall be appointed for a term of two years, four shall be appointed for a term of three years and three shall be appointed for a term of four years. Thereafter, all terms shall be for four years, except that an appointment to fill a vacancy shall be for the unexpired term.

(d) Eight members shall constitute a quorum provided that at least one member from each of the control boards is present. The affirmative vote of a majority of all the members of the agency duly recorded showing how each member voted shall be required in order to take action adopting policies, standards, rules and regulations. The agency shall meet at least twice monthly. Special meetings may be called by the chairman or at the request of a majority of the members of the agency.

(e) The agency shall elect one of its members as chairman and each of the control boards shall also elect one of its members as chairman. The chairman of the agency and of each of the control boards shall, when present, preside at all meetings of the agency or control board, as the case may be, and in his absence a member designated by such chairman shall preside.

(f) The agency may appoint an executive director and hire or engage such other employes or consultants as may be deemed necessary to carry out the powers and duties imposed on the agency by this act. Such executive director and such other employes or consultants shall perform such duties, not contrary to law, as the agency shall prescribe and shall receive such

compensation as the agency shall determine.

(g) Annual salaries of the members of the agency shall be payable in equal installments every other week, as follows:

To the chairman of the agency..... $19,000

To the members of the agency..... 18,000

(h) Except as otherwise expressly provided by law, the agency shall be subject to all the provisions of the act of April 9, 1929 (P.L.177), known as "The Administrative Code of 1929," which apply generally to independent administrative boards and commissions.

Section 4. Powers and Duties of the Agency.--The agency shall have the power and its duty shall be:

(1) To develop a master plan for health services and health care within the Commonwealth to assure quality service and care to each resident at the least possible cost. Such master plan shall be known as "The Pennsylvania Health System."

(2) To approve the schedules of rates, payments, reimbursements, grants and other charges for hospital and health related services rendered by any hospital or health care facility.

(3) To approve the utilization of facilities and equipment at any hospital or health care facility.

(4) To approve the educational and teaching programs conducted at any hospital or health care facility.

(5) To approve all systems of budgets, accounting and record keeping and reporting at any hospital or health care facility.

(6) To make investigations and audits of the operations and financial affairs of any hospital or health care facility.

(7) To approve the number of personnel employed by any hospital or health care facility and the compensation paid to

such personnel.

(8) To approve the plans for new construction or expansion of existing facilities at any hospital or health care facility; to formulate programs for funding such plans and to administer all such programs.

(9) To approve the classification of risks and the premium rates of any policies of insurance covering costs of hospitalization issued by insurance companies which are subject to the jurisdiction of the Insurance Commissioner of the Commonwealth.

(10) To approve the accounting, bookkeeping, billing and record keeping procedures of all health care personnel who bill insurance companies or some other third party for health care or services.

(11) To require financial and operational reports from hospitals, health care facilities and health care personnel and to perform audits and investigations relative to the enforcement thereof.

(12) To approve the curricula, standards for teachers and requirements for graduation or successful completion of any course of study or training given for health care personnel within the Commonwealth.

(13) To approve the number of health care personnel to be trained or taught at any skill level or profession within the Commonwealth.

(14) To promulgate such rules and regulations, not inconsistent with law, necessary for the proper administration and enforcement of the provisions of this act.

All of the powers and duties herein imposed upon the agency shall also be applicable to each of the control boards of the

agency. The agency shall determine the areas of responsibility for each of the control boards.

Section 5. Duties of Hospitals, Health Care Facilities and Health Care Personnel.--It shall be the duty of all hospitals, health care facilities and health care personnel:

(1) To submit to the agency for approval the schedules of rates, payments, reimbursements, grants and charges for hospital and health related services rendered by such hospitals or health care centers.

(2) To submit to the agency for approval any plans for new construction or expansion of existing facilities at any such hospital or health care center.

(3) To submit to the agency for approval a plan for the utilization of all facilities at any such hospital or health care center.

(4) To submit to the agency for approval all teaching and educational programs to be conducted at any such hospital or health care center.

(5) To file all reports required by the agency relating to the operational or financial status of any such hospital or health care center and to cooperate with agents of the agency investigating or conducting audits relating to such matter.

(6) To establish and use such systems of budgets, accounting, record keeping and reporting at any such hospital or health care center as the agency may require.

(7) To comply with all orders, rules and regulations of the agency relating to such hospitals, health care centers or health care personnel.

Section 6. Duties of Certain Insurance Companies.--(a) Any insurance company which is subject to the jurisdiction of the

Insurance Commissioner of the Commonwealth which issues policies of insurance covering the costs of hospitalization shall, in addition to any similar requirements by any other law, file with the agency a copy of the classification of risks and the premium rates pertaining to such insurance.

(b) No policy of insurance covering the costs of hospitalization shall be issued or delivered by any insurance company, which is subject to the jurisdiction of the Insurance Commissioner of the Commonwealth, to any person in this Commonwealth until the provisions of subsections (a) and (c) of this section are complied with.

(c) In addition to any other approval which may be required by law, the classification of risks and the premium rates of any such policies of insurance covering costs of hospitalization must be approved by the agency.

Section 7. Procedure Before the Agency or Control Boards.--(a) The agency or any control board may on its own motion or shall upon the petition of any hospital, health care center, health care personnel or insurance company within the scope of this act, after ten days' written notice, conduct a hearing on any matter which the agency or control board has the power and duty to grant its approval.

(b) All hearings before the agency or any control board shall be public, and shall be conducted in accordance with such regulations as the agency or control board may prescribe. A full and complete record shall be kept of all proceedings had before the agency or control board on any formal hearing, and all testimony shall be taken down by a reporter appointed by the agency or control board, and the parties shall be entitled to be heard in person or by attorney, and to introduce evidence.

(c) The agency or control board shall have the power, in any part of the Commonwealth, to subpoena witnesses, to administer oaths, to examine witnesses, or to take such testimony, or compel the production of such books, records, papers, and documents as it may deem necessary or proper in, and pertinent to, any proceeding, investigation, or hearing, held or had by it, and to do all necessary and proper things and acts in the lawful exercise of its powers or the performance of its duties. The fees for serving a subpoena shall be the same as those paid sheriffs for similar services.

(d) The agency or control board may, on its own motion and whenever it may be necessary in the performance of its duties, investigate and examine any hospital, health care center or health care personnel or insurance company subject to this act. In conducting such investigations the agency or control board may proceed, either with or without a hearing, as it may deem best, but it shall make no order without affording the parties affected thereby a hearing.

(e) After the conclusion of the hearing, the agency or control board shall make and file its findings and order with its opinion, if any. Its findings shall be in sufficient detail to enable the court on appeal, to determine the controverted question presented by the proceeding, and whether proper weight was given to the evidence. A copy of such order, certified under the seal of the agency, shall be served by registered mail upon the hospital, health care center or health care personnel or insurance company against whom it runs, or its attorney, and notice thereof shall be given to the other parties to the proceedings or their attorney. Such order shall take effect and become operative as designated therein, and shall continue in

force either for a period which may be designated therein, or until changed or revoked by the agency or control board. If an order cannot, in the judgment of the agency or control board, be complied with within the time designated therein, the agency or control board may grant and prescribe such additional time as, in its judgment, is reasonably necessary to comply with the order, and may, on application and for good cause shown, extend the time for compliance fixed in its order.

(f) The agency or control board may, at any time, after notice and after opportunity to be heard, rescind or amend any order made by it. Any order rescinding or amending a prior order shall, when served upon the hospital, health care center, health care personnel or insurance company affected, and after notice thereof is given to the other parties to the proceedings, have the same effect as is herein provided for original orders; but no such order shall affect the legality or validity of any acts done by such hospital, health care center, health care personnel or insurance company before service by registered mail upon such person, corporation, or municipal corporation of the notice of such change.

(g) Within thirty days after the service of any order by a control board, any party to the proceedings affected thereby may appeal therefrom to the entire membership of the agency.

Section 8. Appeals to Courts.--(a) Within thirty days after the service of any order by the agency, any party to the proceedings affected thereby may appeal therefrom to the Superior Court. Such court is hereby clothed with exclusive jurisdiction throughout the Commonwealth for the purpose of hearing and determining any and all such appeals. If an appeal be taken to any court other than the Superior Court, the case

shall proceed in accordance with the practice and procedure made and provided in such cases.

(b) All appeals to the Superior Court shall be by petition, setting forth specifically and concisely the error or errors assigned to the order of the agency, which petition shall be accompanied by a copy of the order appealed from, and shall also be accompanied by affidavit of the appellant, or of the agent or attorney of such appellant, that the appeal is not taken for the purpose of delay, but because the appellant believes that injustice has been done. Each error relied on must be specified particularly and set forth in a separate numbered paragraph of the petition.

Section 9. Penalties.--Any person, whether or not an officer, agent, or employe, of any hospital, health care center or insurance company, who or which shall knowingly fail, omit, neglect or refuse to obey, observe, and comply with any regulation or final order, direction, or requirement of the agency or control board, or any order of the agency or control board prescribing temporary rates in any rate proceeding, or any final order or decree of any court, or who shall knowingly procure, aid, or abet any such violation, omission, failure, neglect, or refusal, shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay the costs of prosecution and a fine of not more than five hundred dollars ($500), or undergo imprisonment for not less than one month nor more than one year, or both, at the discretion of the court; and upon conviction of any subsequent offense shall be sentenced to pay the cost of prosecution and a fine of not more than one thousand dollars ($1,000), or undergo imprisonment for not less than three months nor more than two years, or both, at the

discretion of the court.

Section 10. Appropriation.--The sum of one million dollars ($1,000,000), or as much thereof as may be necessary, is hereby specifically appropriated to the Pennsylvania Health Agency, for the fiscal year beginning July 1, 1971 and ending June 30, 1972, for the purpose of the administration and enforcement of the provisions of this act.

Section 11. Effective Date.--This act shall take effect immediately.

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 2183 Session of 1970

INTRODUCED BY MESSRS. GELFAND, SCHMITT, ZEARFOSS, GALLAGHER, BERKES, PEZAK, SHERMAN, TAYLOR, HOPKINS, FRANK, BLAIR AND POLASKI, MARCH 17, 1970

REFERRED TO COMMITTEE ON CONSUMER PROTECTION, MARCH 17, 1970

AN ACT

Creating the Pennsylvania Health Agency as an independent administrative agency; defining the powers and duties of such agency; regulating the delivery, furnishing, planning, providing and sale of all health and medical services and products within the Commonwealth and regulating the construction and purchase of capital facilities used therein; providing procedures for the enforcement of the provisions of the act; making an appropriation and providing penalties.

THE GENERAL ASSEMBLY OF THE COMMONWEALTH OF PENNSYLVANIA HEREBY ENACTS AS FOLLOWS:

Section 1. Short Title.--This act shall be known and may be cited as the "Pennsylvania Health Agency Act."

Section 2. Definitions.--As used in this act - -

(1) "Agency" means the Pennsylvania Health Agency.

(2) "Control board" means one of the five designated boards of the agency.

(3) "Hospital" means any premises, other than a mental health establishment, operated for profit, or being a nonprofit institution, having an organized medical staff and providing equipment and services primarily for inpatient care for two or more individuals who require definitive diagnosis and/or treatment for illness, injury or other disability or during or after pregnancy, and which also regularly makes available at least clinical laboratory services, diagnostic X-ray services and definitive clinical treatment services. The term shall include such premises providing either diagnosis or treatment, or both, for specific illnesses or conditions.

(4) "Health care facilities" means any premises not included or specifically excluded in the definition of "hospital" and used in the performance of health care or services except the office of an individual practicing physician shall not be included.

(5) "Health care personnel" means all persons, whether professional or nonprofessional, involved in any manner in rendering health care or services.

Section 3. Pennsylvania Health Agency.--(a) An independent administrative agency to be known as the "Pennsylvania Health Agency" is hereby created. The agency shall be divided into five control boards as follows: (i) the Hospital Control Board; (ii) the Health Services Control Board; (iii) the Health Profession Control Board; (iv) the Health Facilities Control Board; and (v) the Health Planning Board.

(b) The agency shall consist of fifteen members, three of whom shall also serve as members of the Hospital Control Board, three of whom shall also serve on the Health Services Board, three of whom shall also serve on the Health Profession Control Board, three of whom shall also serve on the Health Facilities Control Board, and three of whom shall serve on the Health Planning Board. Each member shall be appointed by the Governor, by and with the advice and consent of two-thirds of all the members of the Senate, and shall, except as hereinafter provided, hold office for terms of four years each and until his successor has been appointed and qualified.

(c) Of the members first appointed, four shall be appointed for a term of one year, four shall be appointed for a term of two years, four shall be appointed for a term of three years and three shall be appointed for a term of four years. Thereafter, all terms shall be for four years, except that an appointment to fill a vacancy shall be for the unexpired term.

(d) Eight members shall constitute a quorum provided that at least one member from each of the control boards is present. The affirmative vote of a majority of all the members of the agency duly recorded showing how each member voted shall be required in order to take action adopting policies, standards, rules and regulations. The agency shall meet at least twice monthly. Special meetings may be called by the chairman or at the request of a majority of the members of the agency.

(e) The agency shall elect one of its members as chairman and each of the

control boards shall also elect one of its members as chairman. The chairman of the agency and of each of the control boards shall, when present, preside at all meetings of the agency or control board, as the case may be, and in his absence a member designated by such chairman shall preside.

(f) The agency may appoint an executive director and hire or engage such other employes or consultants as may be deemed necessary to carry out the powers and duties imposed on the agency by this act. Such executive director and such other employes or consultants shall perform such duties, not contrary to law, as the agency shall prescribe and shall receive such compensation as the agency shall determine.

(g) Annual salaries of the members of the agency shall be payable in equal installments every other week, as follows:

To the chairman of the agency..... $19,000

To the members of the agency 18,000

(h) Except as otherwise expressly provided by law, the agency shall be subject to all the provisions of the act of April 9, 1929 (P. L. 177), known as "The Administrative Code of 1929," as amended, which apply generally to independent administrative boards and commissions.

Section 4. Powers and Duties of the Agency.--The agency shall have the power and its duty shall be:

(1) To develop a master plan for health services and health care within the Commonwealth to assure quality service and care to each resident at the least possible cost. Such master plan shall be known as "The Pennsylvania Health System."

(2) To approve the schedules of rates, payments, reimbursements, grants and other charges for hospital and health related services rendered by any hospital or health care facility.

(3) To approve the utilization of facilities and equipment at any hospital or health care facility.

(4) To approve the educational and teaching programs conducted at any hospital or health care facility.

(5) To approve all systems of budgets, accounting and record keeping and

reporting at any hospital or health care facility.

(6) To make investigations and audits of the operations and financial affairs of any hospital or health care facility.

(7) To approve the number of personnel employed by any hospital or health care facility and the compensation paid to such personnel.

(8) To approve the plans for new construction or expansion of existing facilities at any hospital or health care facility; to formulate programs for funding such plans and to administer all such programs.

(9) To approve the classification of risks and the premium rates of any policies of insurance covering costs of hospitalization issued by insurance companies which are subject to the jurisdiction of the Insurance Commissioner of the Commonwealth.

(10) To approve the accounting, bookkeeping, billing and record keeping procedures of all health care personnel who bill insurance companies or some other third party for health care or services.

(11) To require financial and operational reports from hospitals, health care facilities and health care personnel and to perform audits and investigations relative to the enforcement thereof.

(12) To approve the curricula, standards for teachers and requirements for graduation or successful completion of any course of study or training given for health care personnel within the Commonwealth.

(13) To approve the number of health care personnel to be trained or taught at any skill level or profession within the Commonwealth.

(14) To promulgate such rules and regulations, not inconsistent with law, necessary for the proper administration and enforcement of the provisions of this act.

All of the powers and duties herein imposed upon the agency shall also be applicable to each of the control boards of the agency. The agency shall determine the areas of responsibility for each of the control boards.

Section 5. Duties of Hospitals, Health Care Facilities and Health Care Personnel.--It shall be the duty of all hospitals, health care facilities and health care personnel, as herein defined:

(1) To submit to the agency for approval the schedules of rates, payments, reimbursements, grants and charges for hospital and health related services rendered by such hospitals or health care centers.

(2) To submit to the agency for approval any plans for new construction or expansion of existing facilities at any such hospital or health care center.

(3) To submit to the agency for approval a plan for the utilization of all facilities at any such hospital or health care center.

(4) To submit to the agency for approval all teaching and educational programs to be conducted at any such hospital or health care center.

(5) To file all reports required by the agency relating to the operational or financial status of any such hospital or health care center and to cooperate with agents of the agency investigating or conducting audits relating to such matter.

(6) To establish and use such systems of budgets, accounting, record keeping and reporting at any such hospital or health care center as the agency may require.

(7) To comply with all orders, rules and regulations of the agency relating to such hospitals, health care centers or health care personnel.

Section 6. Duties of Certain Insurance Companies.--(a) Any insurance company which is subject to the jurisdiction of the Insurance Commissioner of the Commonwealth which issue policies of insurance covering the costs of hospitalization shall, in addition to any similar requirements by any other law, file with the agency a copy of the classification of risks and the premium rates pertaining to such insurance.

(b) No policy of insurance covering the costs of hospitalization shall be issued or delivered by any insurance company, which is subject to the jurisdiction of the Insurance Commissioner of the Commonwealth, to any person in this Commonwealth until the provisions of subsections (a) and (c) of this section are complied with.

(c) In addition to any other approval which may be required by law, the classification of risks and the premium rates of any such policies of insurance covering costs of hospitalization must be approved by the agency.

Section 7. Procedure Before the Agency or Control Boards.--(a) The agency or any control board may on its own motion or shall upon the petition of any hospital,

health care center, health care personnel or insurance company within the scope of this act, after ten days' written notice, conduct a hearing on any matter which the agency or control board has the power and duty to grant its approval.

(b) All hearings before the agency or any control board shall be public, and shall be conducted in accordance with such regulations as the agency or control board may prescribe. A full and complete record shall be kept of all proceedings had before the agency or control board on any formal hearing, and all testimony shall be taken down by a reporter appointed by the agency or control board, and the parties shall be entitled to be heard in person or by attorney, and to introduce evidence.

(c) The agency or control board shall have the power, in any part of the Commonwealth, to subpoena witnesses, to administer oaths, to examine witnesses, or to take such testimony, or compel the production of such books, records, papers, and documents as it may deem necessary or proper in, and pertinent to, any proceeding, investigation, or hearing, held or had by it, and to do all necessary and proper things and acts in the lawful exercise of its powers or the performance of its duties. The fees for serving a subpoena shall be the same as those paid sheriffs for similar services.

(d) The agency or control board may, on its own motion and whenever it may be necessary in the performance of its duties, investigate and examine any hospital, health care center or health care personnel or insurance company subject to this act. In conducting such investigations the agency or control board may proceed, either with or without a hearing, as it may deem best, but it shall make no order without affording the parties affected thereby a hearing.

(e) After the conclusion of the hearing, the agency or control board shall make and file its findings and order with its opinion, if any. Its findings shall be in sufficient detail to enable the court on appeal, to determine the controverted question presented by the proceeding, and whether proper weight was given to the evidence. A copy of such order, certified under the seal of the agency, shall be served by registered mail upon the hospital, health care center or health care personnel or insurance company against whom it runs, or its attorney, and notice thereof shall be given to the other parties to the proceedings or their attorney. Such order shall take effect and become

operative as designated therein, and shall continue in force either for a period which may be designated therein, or until changed or revoked by the agency or control board. If an order cannot, in the judgment of the agency or control board, be complied with within the time designated therein, the agency or control board may grant and prescribe such additional time as, in its judgment, is reasonably necessary to comply with the order, and may, on application and for good cause shown, extend the time for compliance fixed in its order.

(f) The agency or control board may, at any time, after notice and after opportunity to be heard, rescind or amend any order made by it. Any order rescinding or amending a prior order shall, when served upon the hospital, health care center, health care personnel or insurance company affected, and after notice thereof is given to the other parties to the proceedings, have the same effect as is herein provided for original orders; but no such order shall affect the legality or validity of any acts done by such hospital, health care center, health care personnel or insurance company before service by registered mail upon such person, corporation, or municipal corporation of the notice of such change.

(g) Within thirty days after the service of any order by a control board, any party to the proceedings affected thereby may appeal therefrom to the entire membership of the agency.

Section 8. Appeals to Courts.--(a) Within thirty days after the service of any order by the agency, any party to the proceedings affected thereby may appeal therefrom to the Superior Court. Such court is hereby clothed with exclusive jurisdiction throughout the Commonwealth for the purpose of hearing and determining any and all such appeals. If an appeal be taken to any court other than the Superior Court, the case shall proceed in accordance with the practice and procedure made and provided in such cases.

(b) All appeals to the Superior Court shall be by petition, setting forth specifically and concisely the error or errors assigned to the order of the agency, which petition shall be accompanied by a copy of the order appealed from, and shall also be accompanied by affidavit of the appellant, or of the agent or attorney of such appellant, that the appeal is not taken for the purpose of delay, but because the appellant verily believes

that injustice has been done. Each error relied on must be specified particularly and set forth in a separate numbered paragraph of the petition.

Section 9. Penalties.--Any person, whether or not an officer, agent, or employe, of any hospital, health care center or insurance company, who or which shall knowingly fail, omit, neglect or refuse to obey, observe, and comply with any regulation or final order, direction, or requirement of the agency or control board, or any order of the agency or control board prescribing temporary rates in any rate proceeding, or any final order or decree of any court, or who shall knowingly procure, aid, or abet any such violation, omission, failure, neglect, or refusal, shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay the costs of prosecution and a fine of not more than five hundred dollars ($500), or undergo imprisonment for not less than one month nor more than one year, or both, at the discretion of the court; and upon conviction of any subsequent offense shall be sentenced to pay the costs of prosecution and a fine of not more than one thousand dollars ($1,000), or undergo imprisonment for not less than three months nor more than two years, or both, at the discretion of the court.

Section 10. Appropriation.--The sum of one million dollars ($1,000,000), or as much thereof as may be necessary, is hereby specifically appropriated to the Pennsylvania Health Agency, for the fiscal year beginning July 1, 1970 and ending June 30, 1971, for the purpose of the administration and enforcement of the provisions of this act.

Section 11. Effective Date.--This act shall take effect immediately.

SEP 15 1969 33

Printer's No. 1109

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 994 Session of 1969

INTRODUCED BY KLINE, OESTERLING, PECHAN, WOOD AND KALMAN, JULY 22, 1969

REFERRED TO PUBLIC HEALTH AND WELFARE, JULY 22, 1969

AN ACT

Creating the Pennsylvania Hospital Control Commission as an independent administrative commission; defining the powers and duties of such commission; regulating the various rates charged by all hospitals within the Commonwealth; controlling the construction and utilization of such hospitals; regulating the premium rates for hospitalization insurance within the Commonwealth; providing procedures for the enforcement of the provisions of the act and providing penalties.

THE GENERAL ASSEMBLY OF THE COMMONWEALTH OF PENNSYLVANIA HEREBY ENACTS AS FOLLOWS:

Section 1. Short Title.--This act shall be known and may be cited as the "Pennsylvania Hospital Control Commission Act."

Section 2. Legislative Findings.--Rising hospital costs are a matter of vital concern to the people of this State. The relentless increases in such costs encountered in recent years pose dangers to all purchasers of hospital services as well as hospitals themselves. The cost of hospital care is increasing faster than any other item in the consumer price index. The individual consumer has been spending a larger share of his earnings on hospital care and the average cost per hospital stay continues to rise disproportionately to the increase in per capita income.

In part, hospital cost increases result from necessary improvement in wages and fringe benefits for hospital workers, improvements in equipment and service, and enhanced capability to save lives. However, while improved quality of services, increased use of facilities and rising prices are factors in accelerating hospital costs,

there are nevertheless wide unexplained variations in the cost of the same services rendered by hospitals in the same area. Continued pressure for unnecessary duplication of facilities and heavy standby commitments for under-utilized services in one area contrast with long waiting lists for admission to facilities in other areas. Inefficient management and resultant higher costs need to be eliminated lest they threaten access to care and emergency services for many of our citizens.

The Legislature therefore finds and declares that it is essential that an effective cost control program be established which will both enable and motivate hospitals to control their spiraling costs. It is the intent of this act to provide for uniform measures on a Statewide basis to control hospital costs without the sacrifice of quality of service.

Section 3. Definitions.--As used in this act--

"Commission" means the Pennsylvania Hospital Control Commission.

"Hospital" means any premises, other than a mental health establishment operated for profit, or being a nonprofit institution, having an organized medical staff and providing equipment and services primarily for inpatient care for two or more individuals who require definitive diagnosis and/or treatment for illness, injury or other disability or during or after pregnancy, and which also regularly makes available at least clinical laboratory services, diagnostic X-ray services and definitive clinical treatment services. The term shall include such premises providing either diagnosis or treatment, or both, for specific illnesses or conditions.

Section 4. Pennsylvania Hospital Control Commission.--(a) An independent administrative commission to be known as the "Pennsylvania Hospital Control Commission" is hereby created. The commission shall consist of three members to be appointed by the Governor by and with the advice and consent of two-thirds of all members of the Senate. Of the original members, one shall be appointed for a term of two years, one for a term of four years, and one for a term of six years from the date of his appointment and until his successor shall have been appointed and qualified. Thereafter, all appointments shall be for terms of six years or until successors are appointed and qualified.

(b) Each member of the commission at the time of his appointment and qualification shall be a citizen of the United States and a resident of the Commonwealth of

Pennsylvania and shall have been a qualified elector in the Commonwealth for a period of at least one year next preceding his appointment. No member of the commission during his period of service as such shall hold any other office under the laws of this Commonwealth or of the United States.

(c) The commission shall elect one of its members as chairman. The chairman shall, when present, preside at all meetings, and in his absence a member designated by the chairman shall preside. Two members of the commission shall constitute a quorum, and any action or order of the commission shall require the approval of at least two members.

(d) The commission may appoint an executive director and hire or engage such other employes or consultants as may be deemed necessary to carry out the powers and duties imposed on the commission by this act. Such executive director and such other employes or consultants shall perform such duties, not contrary to law, as the commission shall prescribe and shall receive such compensation as the commission shall determine.

(e) Annual salaries of the members of the commission shall be payable in equal installments every other week, as follows:

To the chairman of the commission..... $19,000

To the members of the commission..... 18,000

(f) Except as otherwise expressly provided by law, the commission shall be subject to all the provisions of the act of April 9, 1929 (P. L. 177), known as "The Administrative Code of 1929," as amended, which apply generally to independent administrative boards and commissions.

Section 5. Duties of Hospitals; Operating Certificates.—(a) It shall be the duty of every hospital within the Commonwealth, as herein defined:

(1) To submit to the commission for approval the schedules of rates, payments, reimbursements, grants and charges for hospital and health related services rendered by such hospital;

(2) To submit to the commission for approval any plans for new construction or expansion of existing facilities at any such hospital;

(3) To submit to the commission for approval a plan for the utilization of all facilities at any such hospital.

(b) Every hospital within the Commonwealth, as herein defined, shall be subject to the provisions of this act and must obtain from the commission an operating certificate, the possession of which shall be necessary for the rendering of any service by such hospital.

Section 6. Duties of Certain Insurance Companies.—Any insurance company which is subject to the jurisdiction of the Insurance Commissioner of the Commonwealth which issue policies of insurance covering the costs of hospitalization shall, in addition to any similar requirements by any other law, file with the commission a copy of the classification of risks and the premium rates pertaining to such insurance.

(b) No policy of insurance covering the costs of hospitalization shall be issued or delivered by any insurance company, which is subject to the jurisdiction of the Insurance Commissioner of the Commonwealth, to any person in this Commonwealth until the provisions of subsections (a) and (c) of this section are complied with.

(c) In addition to any other approval which may be required by law, the classification of risks and the premium rates of any such policies of insurance covering costs of hospitalization must be approved by the commission.

Section 7. Powers and Duties of the Commission.—The commission shall have the power and its duty shall be:

(1) To grant operating licenses to hospitals which comply with the provisions of this act;

(2) To approve the schedules of rates, payments, reimbursements, grants and other charges for hospital and health related services rendered by each hospital;

(3) To approve the plans for new construction or expansion of existing facilities at any hospital;

(4) To approve the plans for the utilization of facilities at any hospital;

(5) To approve the classification of risks and the premium rates of any policies of insurance covering costs of hospitalization issued by insurance companies which are subject to the jurisdiction of the Insurance Commissioner of the Commonwealth; and

(6) To promulgate such rules and regulations, not inconsistent with law, necessary for the proper administration of the provisions of this act.

Section 8. Procedure Before the Commission.--(a) The commission may on its own motion or shall upon the petition of any hospital or insurance company within the scope of this act, after ten days' written notice, conduct a hearing on any matter which the commission has the power and duty to grant its approval.

(b) All hearings before the commission shall be public, and shall be conducted in accordance with such regulations as the commission may prescribe. A full and complete record shall be kept of all proceedings had before the commission on any formal hearing, and all testimony shall be taken down by a reporter appointed by the commission, and the parties shall be entitled to be heard in person or by attorney, and to introduce evidence.

(c) The commission shall have the power, in any part of the Commonwealth, to subpoena witnesses, to administer oaths, to examine witnesses, or to take such testimony, or compel the production of such books, records, papers, and documents as it may deem necessary or proper in, and pertinent to, any proceeding, investigation, or hearing, held or had by it, and to do all necessary and proper things and acts in the lawful exercise of its powers or the performance of its duties. The fees for serving a subpoena shall be the same as those paid sheriffs for similar services.

(d) The commission may, on its own motion and whenever it may be necessary in the performance of its duties, investigate and examine any hospital or insurance company subject to this act. In conducting such investigations the commission may proceed, either with or without a hearing, as it may deem best, but it shall make no order without affording the parties affected thereby a hearing.

(e) After the conclusion of the hearing, the commission shall make and file its findings and order with its opinion, if any. Its findings shall be in sufficient detail to enable the court on appeal, to determine the controverted question presented by the proceeding, and whether proper weight was given to the evidence. A copy of such order, certified under the seal of the commission, shall be served by registered mail upon the hospital or insurance company against whom it runs, or its attorney, and notice thereof

shall be given to the other parties to the proceedings or their attorney. Such order shall take effect and become operative as designated therein, and shall continue in force either for a period which may be designated therein, or until changed or revoked by the commission. If an order cannot, in the judgment of the commission, be complied with within the time designated therein, the commission may grant and prescribe such additional time as, in its judgment, is reasonably necessary to comply with the order, and may, on application and for good cause shown, extend the time for compliance fixed in its order.

(f) The commission may, at any time, after notice and after opportunity to be heard, rescind or amend any order made by it. Any order rescinding or amending a prior order shall, when served upon the hospital or insurance company affected, and after notice thereof is given to the other parties to the proceedings, have the same effect as is herein provided for original orders; but no such order shall affect the legality or validity of any acts done by such hospital or insurance company before service by registered mail upon such person, corporation, or municipal corporation of the notice of such change.

Section 9. Appeals to Courts.--(a) Within thirty days after the service of any order by the commission, any party to the proceedings affected thereby may appeal therefrom to the Superior Court. Such court is hereby clothed with exclusive jurisdiction throughout the Commonwealth for the purpose of hearing and determining any and all such appeals. If an appeal be taken to any court other than the Superior Court, the case shall proceed in accordance with the practice and procedure made and provided in such cases.

(b) All appeals to the Superior Court shall be by petition, setting forth specifically and concisely the error or errors assigned to the order of the commission, which petition shall be accompanied by a copy of the order appealed from, and shall also be accompanied by affidavit of the appellant, or of the agent or attorney of such appellant, that the appeal is not taken for the purpose of delay, but because the appellant verily believes that injustice has been done. Each error relied on must be specified particularly and set forth in a separate numbered paragraph of the petition.

Exhibit 33E

Section 10. Penalties.--Any person, whether or not an officer, agent, or employe, of any hospital or insurance company, who or which shall knowingly fail, omit, neglect or refuse to obey, observe, and comply with any regulation or final order, direction, or requirement of the commission, or any order of the commission prescribing temporary rates in any rate proceeding, or any final order or decree of any court, or who shall knowingly procure, aid, or abet any such violation, omission, failure, neglect, or refusal, shall be guilty of a misdemeanor, and, upon conviction thereof, shall be sentenced to pay the costs of prosecution and a fine of not more than five hundred dollars ($500), or undergo imprisonment for not less than one month nor more than one year, or both, at the discretion of the court; and upon conviction of any subsequent offense shall be sentenced to pay the costs of prosecution and a fine of not more than one thousand dollars ($1,000), or undergo imprisonment for not less than three months nor more than two years, or both, at the discretion of the court.

Exhibit 35

PRINCIPLES OF PAYMENT FOR HOSPITAL CARE

THE GROWTH OF PROGRAMS by which third-party agencies pay hospital bills for groups of beneficiaries has raised important questions as to the amounts which should be paid to hospitals for care. Individual patients require different services and individual hospitals establish different regular charges for nominally similar services.

The differences in patient needs and hospital charges require special agreements between hospitals and third-party agencies whenever the former agree to furnish specific services, and the latter agree to make payments for those services. The payments must be adequate in total and equitable among hospitals.

A third party's liability to a hospital may be merely the payment of a certain dollar amount (indemnity or cash benefit) toward the charges for services rendered. Such liability does not require a contractual arrangement between the hospitals and third-party agencies, except for such matters as extension of credit to patients or authority to make payments directly to the hospitals.

Any contract to provide service should protect a hospital's financial interest and its program of public service. Payments should encourage high standards, administrative efficiency, institutional freedom, and the rendering of service in the interest of patient welfare.

Two broad bases are available for developing a method of reimbursement of hospitals for service benefits, namely the *"charges" established* by the hospitals and the *"costs" incurred* by them.

The prevailing sociologic and economic factors and medico-hospital relationships in a given area determine the degree of success or failure of any method of payment

for hospital care. Because of the general public interest in hospital operations, any method of payment which enables a single agency to control the number of services rendered to patients and the charges established for such service is undesirable. Such control leads to interference in hospital management and can affect adversely the quality of care rendered to patients. Therefore, a system of payment which permits purchasers of large quantities of hospital care to gain control of hospital management is to be avoided.

Payment of existing charges, as established from time to time by each institution, requires no special contractual arrangement between the hospital and the third-party agency. Any patient or his financial sponsor is privileged to pay established charges if he has the money.

The two conferences sponsored by the American Hospital Association in 1951 and 1953, and attended by representatives of both hospitals and third-party agencies, made only passing reference to established charges as the basis of contract payment for services in hospitals. The conference reports expressed the view that reimbursement from third parties should not exceed the amounts charged to non-contract patients receiving similar care in the same hospitals.

Under the principle of free enterprise, individual full-pay patients would expect to pay approximately the same amounts for the same services in the same community. But in the long run, established charges to individual patients cannot be expected to control the amounts paid by large-scale contractors who guarantee definite payments for all their clients. The amount paid by such a contracting agency will tend to equal the cost of the services rendered to its clients.

A hospital or group of hospitals must, over a period of time, be reimbursed for the "full" cost of services

which they provide. Conversely, all responsible third-party contractors should be prepared to pay for the full costs of services furnished to their beneficiaries. Many problems must be solved in the application of this fundamental principle.

Individual hospitals face different financial problems. But they must deal with contracting agencies as a group. A contractual arrangement within a community must be guided by equity for the majority of hospitals which agree to provide service.

The following principles of payment are intended to outline standards of adequacy and equity for contract payments for services furnished by hospitals to beneficiaries of third-party agencies, such as Blue Cross Plans, governmental bodies and other organizations which engage in the purchase of hospital services on behalf of groups of individuals.

1.000 BASIS FOR PAYMENT

The amount and method of payment to hospitals should be such as (1) to pay fairly and adequately for services purchased, (2) to maintain essential services, and (3) to encourage the development of higher standards of service to meet the needs of the community. 1.100

COMMENT . . . *The financing of hospital care requires recognition of the need for expanding health services with their attendant requirements. The hospital administrator and the medical staff must have assurance that the amount and method of payment will be adequate to cover the current costs of pro-*

viding the services which are requisite to necessary care, and that payments can be adjusted from time to time to meet the cost of expanded and improved quality of care.

1.200 Agencies purchasing hospital services should pay the "full cost" incurred in providing services for which they are responsible under their agreements with hospitals.

COMMENT . . . *Hospital income from patients whose bills are the responsibility of a third party should equal the "full cost" incurred by the hospital in providing a high quality of care. The term "full cost" as used here assumes the acceptance of definitions of cost in the succeeding sections of this report. This principle also implies that both parties (agency and hospital) are agreed as to contract services that are to be provided and as to the method of computing the contract payments that are to be made.*

1.201 A hospital should apply uniform principles for determining rates of reimbursement for similar services for all third-party agencies.

COMMENT . . . *The formulas used for establishing contract payments by third-party agencies should be applied uniformly for all such organizations. The amount of contract payment necessarily will vary for different third-party agencies, if the agencies contract to pay for different types of service for their beneficiaries. The most important principle is that each third-party agency should contract to pay the "full cost" for whatever services are agreed upon.*

1.202 Third-party agencies should not be expected to pay for that portion of the cost of specific cases which has been or will be paid for from other revenues designated for such cases.

COMMENT . . . *A hospital should not receive income for the same service from two separate sources. A hospital however, should not be expected to furnish services below "full cost" to third-party agencies merely because it receives income for general purposes from some other source.*

1.300 Hospitals which are paid the "full cost" of services they render to beneficiaries of third-party purchasers must accept the obligation of making available essential facilities and a high quality of service, with due regard to economy and efficiency.

COMMENT . . . *Hospitals which are paid "full cost" must assume basic obligations to provide essential facilities and high quality service at minimal expense and maximal operational efficiency. The acceptance of this principle involves both self-imposed and externally applied judgments of adequacy, deficiency or extravagance of hospital administration.*

1.400 Established rates to self-paying patients for similar services and accommodations should be based upon and be reasonably related to the "full cost."

COMMENT . . . *Where established rates for self-paying patients are less than "full cost," it is difficult to justify contract payments from third-party agencies that are based on "full cost." Charity and other allowances should be granted on an individual basis and should not be a factor in rate setting. It is not practicable for the charge for every item of service to reflect its individual cost, but the composite regular charges for contract service should at least equal the composite costs of such care.*

1.500 Rates of payment should reflect current hospital costs.

COMMENT . . . *Rates of payment should be related directly to "full cost" in the period in which care is given, insofar as administratively possible. A procedure for retroactive adjustment to current costs should be mutually agreed upon. This principle is important in that hospital costs must be met in terms of current price and wage levels. It is, therefore, in the interest of the third-party agency and the hospital to devise a method by which costs may be computed and payments adjusted promptly to reflect current variations.*

1.600 Payments to different hospitals for the same service may differ.

COMMENT . . . *Hospitals differ in physical design, equipment, accessibility, location, legal responsibilities, community responsi-*

bilities, medical staff, percentage of utilization, and in many other details. For these reasons hospitals may provide comparable quality in specific patient services at varying unit costs.

One hospital frequently is unable to maintain as high a percentage of occupancy or as complete utilization of diagnostic facilities as another institution. This adversely affects costs. But even the resultant higher costs may be justified because of the need for standby service in the community.

2.000 DETERMINATION OF "FULL COST"

The determination of "full cost" principles of payment requires acceptance and use of uniform definitions, accounting, statistics, and reporting. 2.100

COMMENT . . . *Any systematic payment program requires an orderly procedure of reporting in order that the payment program may be administered fairly and expeditiously. Hospitals must agree to provide the basic information necessary for comparable analysis of cost and equitable distribution of payments by third-party purchasers. Reimbursement at "full cost" by third-party agencies is dependent upon their knowledge of the procedures used in providing the data. Only through uniformity of records and reports can third-party agencies be as-*

sured that they are paying for similar services in different hospitals on comparable bases.

2.200 The principles described in the American Hospital Association Handbook on Accounting, Statistics and Business Office Procedures for Hospitals should be used in determining "full cost."

COMMENT . . . *Official standard definitions, accounting procedures, statistical procedures, and methods of reporting among hospitals are those described in the American Hospital Association Handbook on Accounting, Statistics and Business Office Procedures for Hospitals. Their uniform use, nationally will contribute to better accounting by hospitals and better understanding of costs and cost factors by third-party purchasers.*

2.300 It is essential that the principle of reimbursement of hospitals at "full cost" be embodied in a reimbursable cost formula (such as, "The Hospital Statement of Reimbursable Cost, Joint Hospital Form #1"). This may be used to determine the total cost of operations for the purpose of computing a general average cost per inpatient day or other unit of service. Such an average cost figure should be used when applicable to the services which a hospital or hospitals agree to furnish. Under other circumstances the average may serve as a basis for adjustment, up or down, according

to the scope and content of an agreement with respect to cases covered, accommodations used, extent of services, or other major considerations.

Attention is called to the recommendations indicated in 2.301 to 2.311 with respect to certain items which are sufficiently important to justify special mention for inclusion or exclusion in the computation of "full cost."

COMMENT . . . *An average per diem cost, computed under a reimbursable cost formula, such as, the "Hospital Statement of Reimbursable Cost, Joint Hospital Form #1," should be used to establish a rate of payment under contractual agreements with third-party agencies when the patients for whom a contracting agency is responsible are average for the hospital concerned.*

Patients paid for by specific third-party agencies may be atypical for a variety of reasons. For example, all patients might be hospitalized for obstetrical care, and "full cost" for this group might not be average cost for all patients in the hospital. A third-party agency might wish to have all of its beneficiaries hospitalized in semi-private rooms which might cost more than average cost, or all beneficiaries of another agency might be chronic patients requiring long periods of hospitalization with relatively small amounts of special services at less than average cost. In such situations, it may be necessary to develop more detailed cost data

or other factual information for the purpose of demonstrating the extent to which a reimbursable rate should deviate from the overall average patient day cost.

2.301 Major expenditures identifiable as being made for medical research purposes, over and beyond the usual care of patients, should not be included in determining "full cost" of patient care and services.

COMMENT . . . *Research ultimately results in better patient care; its benefits usually are derived over long periods of time and are not always of direct benefit to patients in the hospital at the time the research is being conducted. It is therefore reasonable that such desirable pioneering efforts be financed from sources other than the patients being served in a particular hospital. Such other sources might be eleemosynary foundations, philanthropic contributors, and tax-supported agencies.*

Those paying for hospital care should understand that the quality of care in any hospital is improved by research and that any increased cost is reflected in better care because of the incentive provided for better service by those working in such a hospital.

2.302 In determining "full cost," a reasonable amount for medical, nursing and other education not reimbursed through tuition, scholarships, grants, or other community contributions is a legitimate inclusion in the

interest of continuing to upgrade quality of service to the community. The community should assist ultimately in the support of such educational programs.

COMMENT . . . *Ideally, the cost of educating and training the technical and professional health services personnel needed for community service, for industry, or for other health activities should be financed by the whole community through a combination of public resources and private contributions, rather than by the sick patient representing a small percentage of the community who is usually in the poorest position to meet such cost. It will be necessary, however, that the cost of such programs be considered as a factor in determining "full cost" of hospital service until the community is prepared to assume this educational responsibility. Hospitals and third-party purchasers must seek methods for transferring this cost to the whole community through concerted joint effort. It must be borne in mind that nursing education traditionally has been supported by hospital income and by the service rendered by student nurses in hospitals. While financing from other methods must be developed, nothing must be done to discourage the education of increasing numbers of nurses prior to the time that such cost can be transferred to other sources.*

2.303 Income specifically designated for research or education should be deducted from total

hospital expenses to the extent that expenditures for such items have been included in the total cost.

COMMENT . . . *It appears justifiable to include the expense of some types of applied research and basic training programs as part of the cost of hospital operation. But in the event special contributions, government subsidies, or foundation grants are made available for financing these activities, in part or in full, such amounts should be recognized in the special purpose budget to which they apply as a reduction in the gross amount of the cost of such research or educational projects. To charge the patient for an expense that was met specifically in another manner would mean that income would be derived from two sources for the same expense.*

2.304 **Bad debts, charity and courtesy allowances are not proper items of expense.**

COMMENT . . . *This principle is based on the only acceptable accounting method for calculating these items. Bad debts, charity and courtesy allowances are not expenses, rather they are deductions from income.*

2.305 **Ordinary remodeling is a charge against maintenance and repairs and should be included in expenses. Remodeling which enhances the capital value should be capitalized and therefore not included in reimbursable costs.**

COMMENT . . . *Hospitals are expected to make the necessary expenditures required to maintain the original purpose and efficiency of the plant facilities and to do minor remodeling periodically to improve the efficiency and economy of hospital operations. Such costs are properly chargeable to current operating expense. It is expected that expenditures for extensive remodeling or replacement of buildings for the purpose of enhancing the value of the hospital should be capitalized. Funds for such capital expenditures should be accumulated by regular depreciation allowances included in costs over a period of years or by some other type of financing, such as, public subscription and philanthropic contributions.*

Interest incurred on capital or other indebtedness should be included in determining "full cost." 2.306

COMMENT . . . *A hospital is a public service agency and, as such, represents a public investment in necessary community health facilities. If the public has not provided a debt-free institution, either through extended purchase of care or through public fund-raising campaigns, it must assume responsibility for the payment of debt service charges added to its bill for hospital care.*

The expense incurred by hospitals in providing services of sisters or other members of religious orders shall be accepted as an 2.307

operating expense for the determination of "full cost." The amounts included should not exceed those paid other employees for similar work and should be identifiable in the records of the institution as operating expenses.

COMMENT . . . *Inclusion of a comparable value for the donated services of members of religious orders is a recognition of their contribution to community health and welfare. Equity among hospitals requires that each institution maintain records of the amounts included in the operating expenses for such services, with a list of the individuals for whom the amounts have been calculated. The total amounts may be subdivided in the records according to whether they represent living expenses, special perquisites or salary allowances. Inclusion of such items in operating expenses implies, but does not necessarily require, that equivalent cash disbursements have been made to other agencies or to the individuals listed in the records and reports of the hospital.*

2.308 **Income received from governmental agencies, foundations or others to cover special projects or salaries paid to special employees, who ordinarily would not be employed by the hospital, should be deducted from expenses in the determination of "full cost."**

COMMENT . . . *Under some circumstances a hospital receives income from outside agencies toward the conduct of special projects or for the employment of specially trained personnel required to administer the treatment of specific types of illnesses. Agencies sponsoring such special projects or services should pay the full cost of the services sponsored on their behalf, in order that no part of the cost of these extraordinary projects need be paid by other patients, including the beneficiaries of other third-party agencies.*

"Full cost" should provide for a separate cost for the nursery care of the newborn. 2.309

COMMENT . . . *Present-day standards of specialized care for new-born infants frequently represent a substantial portion of hospital operating expenses. The cost of such care should be computed separately in order that agencies which purchase predominant amounts of maternity care may pay their proportionate share of such hospital operating costs. Such classification of expense would make possible more accurate comparison of adult patient day costs among hospitals, irrespective of the variance in the amount of care provided newborn patients. Such information should also prove useful in determining charges for self-paying patients.*

2.310 Depreciation on buildings and equipment, in accordance with recommendations of the American Hospital Association Handbook on Accounting, Statistics and business Office Procedures for Hospitals, should be included in "full cost" and should be used for replacement of the existing plant.

COMMENT . . .*The inclusion of an item of depreciation in the determination of "full-cost" is necessary to provide for the replacement of depreciated capital assets. Current business procedure does not require that all depreciation included in operating costs be accumulated and set aside in a special cash fund. The rates of depreciation for various capital assets listed in the American Hospital Association Handbook on Accounting, Statistics and Business Office Procedures for Hospitals have gained widespread acceptance in the hospital field.*

2.311 Expenses for inpatient and outpatient services should be segregated according to the method advocated by the American Hospital Association or by a comparable method. Where this is impractical, estimated expenses for outpatient services may be computed by multiplying the total number of outpatient visits by a figure comparable to outpatient department visit costs in similar hospitals in the area.

COMMENT . . . *The payment of cost for hospital care should be related to the services rendered. When paying for inpatient care, therefore, the rates of payment should not include costs of outpatient services. As a practical matter, some hospitals do not maintain cost records necessary for accurate apportionment of expenses between inpatient and outpatient services. In such cases, an equitable and acceptable alternative procedure for determining outpatient cost is outlined in the principle. This estimated cost must be subtracted from the total cost in computing the average per diem inpatient cost for the hospital.*

2.312 Careful studies should be made of methods for adjusting general average costs to determine rates of payment applicable to particular agreements, having regard for their scope and content with respect to cases covered, accommodations used, extent of service, or other major considerations.

COMMENT . . .*There are some factors in the administration of patient care which can be identified and evaluated clearly. Examples are differences in accommodations, such as, single, double, or multiple bedrooms, differences in categories of patients, such as, chronic, aged or maternity, and differences in length of stay. Where these differences in cost can be identified and evaluated, they form a proper basis for adjustments in rates of contract payment.*

2.400 Hospitals should not be required to use income from general endowment funds or unrestricted gifts to reduce third-party payments.

COMMENT . . . *Endowment funds and gifts to hospitals are their property, and it is the responsibility of the hospital governing board to see that such funds are administered in accordance with the wishes of the benefactors or on a basis by which the hospital can best serve the community. The general financial resources of a hospital do not relieve third-party agencies of their responsibility for payment of "full cost" for services provided.*

2.401 Income from endowment funds or gifts designated by donors for the care of specific groups of third-party beneficiaries should be used to reduce third-party payments for persons in such groups.

COMMENT . . . *This principle prevents dual payments to hospitals. However, it must be interpreted with care in order that the endowment fund gift be defined specifically for the group who are the responsibility of the third-party agency. Such reductions in reimbursement from community agencies charged with the financial responsibility for general medical care of its indigent beneficiaries should be applied only to the care of the specific groups of patients for whom the gifts or endowment funds are available. It is not intended in this principle that such reductions in payment be used to affect payments from prepayment plans in which the individual has provided protection for himself through a form of insurance. Also, it is not the intent of this principle that unrestricted gifts or general endowment funds be used to reduce payments from third-party purchasers.*

3.000 OBLIGATIONS IN APPLYING PRINCIPLES OF "FULL COST" PAYMENT

3.100 When hospitals are reimbursed for "full cost," hospitals and third-party agencies have the following obligations and responsibilities:

3.101 Hospitals should assume responsibility for the provision of adequate facilities, competent personnel and high standards of service. Third-party agencies should assume responsibility for making payment for comprehensive hospital services.

COMMENT . . . *Hospital responsibility extends beyond the provision of minimum standards of patient care. Hospitals must incorporate in their health care program all essential services which high quality scientific medicine requires. Adequacy of facilities, personnel and standards of service should be judged on the basis of long-term public need rather than on short-term financial*

considerations. Likewise, third-party purchasers have a responsibility for developing programs by which all such services can be made available to their beneficiaries. Under such programs, third-party agencies must expect to pay the "full cost" of such comprehensive services in order that the hospitals can continue to provide the highest possible quality of service.

3.102 Hospitals and organized groups, in cooperation with third-party agencies, have responsibility for making studies which will lead to constant improvement in administrative and professional practices in both hospitals and third-party agencies. Such studies should be conducted for their educational value rather than for the purpose of establishing arbitrary controls.

COMMENT . . . *This principle does not intend that hospitals and third-party agencies shall conduct independent studies of each other's management, but that the two shall make joint studies of subjects of mutual concern and benefit. As the principle states, such studies will have educational value for the entire community as well as for the agencies concerned.*

3.103 Hospitals and third-party agencies should cooperate in the study of such factors as admission, length of stay, extent and amount

of services provided, and other factors that affect the cost of services to agencies purchasing care, with a view to economical and efficient use of funds.

COMMENT . . . *The consideration of any factors which would tend to reduce the cost of hospitalization without sacrificing quality of care should be of mutual interest to hospitals and third-party purchasers. Continuous study of statistics and data bearing on hospital cost and third-party purchasers' experience should be carried on to promote all possible operational savings and benefits which will inure to the patient, the hospital and the third-party agency.*

3.200 There is mutual responsibility on the part of hospitals and third-party agencies for making available, upon request, such fiscal and administrative statistics and data as are necessary for a continuing agreement on amount of payment and services provided.

COMMENT . . . *A purchasing agency has responsibility to demonstrate on occasions that its stewardship of funds is defensible. Further, the purchasing agency must have access to data regarding the product for purposes of defending such stewardship. Inasmuch as the third-party agency must secure adequate funds for hospital reimbursement, current and accurate data are required for predicting the amount of funds neces-*

sary for the agency to meet its obligations. For these purposes of mutual need, it is necessary that both hospitals and third-party agencies make fiscal and administrative statistics and data available for mutual study and understanding.

3.201 Hospitals receiving payment on the basis of "full cost" agreements should provide accurate cost data which are capable of verification by those third-party purchasers with whom they have such agreements.

COMMENT . . . *Third-party purchasers must obtain adequate cost information from hospitals to which they are paying "full cost" in order to justify the payments they make for hospital care provided their beneficiaries. Such cost information must be kept in a clear and concise form which can be readily analyzed. It is a desirable practice to have an audit of the accounts of an enterprise by qualified, disinterested auditors. Such practice will insure the provision of accurate cost information and is evidence of good faith and sound management.*

3.202 Hospitals are urged to organize in sectional or regional groups so that they may participate in joint service for uniform accounting, reporting and community planning.

COMMENT . . . *Uniformity in accounting, reporting and planning can be achieved*

through joint efforts and formally established lines of communication among hospitals. The promotion and development of uniform accounting and statistics, as outlined in the American Hospital Association Handbook on Accounting, Statistics and Business Office Procedures for Hospitals, as well as many other projects, have been conducted successfully by metropolitan hospital councils, and by state or regional hospital associations.

Assumption of initiative in cooperation with appropriate agencies to develop objective criteria for evaluation of scope and quality of services of hospitals and third-party agencies is the logical responsibility of the American Hospital Association. **3.300**

COMMENT . . . *The mutual interest of hospitals and third-party purchasers in the production and distribution of high quality hospital care suggests the need for a continuing program of self-analysis to insure progress toward common objectives. The American Hospital Association is the logical agency to assume this undertaking, since it follows the established policy of the Association, as evidenced by its sponsorship and participation in a program of hospital accreditation and standardization.*

Ceilings on the amount of payment are not inconsistent with the principle of "full cost" and may be established through conference **3.400**

Exhibit 35

between third-party agencies and contracting hospitals.

COMMENT . . . *Most variations in per diem operating costs among hospitals can be explained satisfactorily by one or a combination of influencing factors. Some variations from the norm, however, result from failure to provide an acceptable service, provision of luxury non-essential services, or poor administrative control. Purchase of care at any price cannot be justified in the instance of hospitals which provide inadequate service. Neither can excessively high rates be justified for payment to hospitals whose administrative policies have resulted in inordinately high costs.*

Exhibit 40

SCHNADER, HARRISON, SEGAL & LEWIS

(Letterhead)

September 26, 1975

Allen W. Stewart, Esquire
Morgan, Lewis & Bockius
2107 The Fidelity Building
Philadelphia, Pennsylvania 19109

Dear Allen:

Enclosed is a copy of my letter of September 25, 1975 to all hospitals represented by DVHC in the current Blue Cross negotiations.

As you can see, I have directed the hospitals to provide Blue Cross with the information requested by both Dr. Baker and George Gannon. I have indicated in the letter that you assured me the information requested by Dr. Baker was being obtained for the sole purpose of establishing the interim per diem rate and would have no effect on final settlement for fiscal 76; and that Gannon is not seeking the information to apply any ceiling to the final settlement for fiscal 75.

If you disagree with either statement in the letter, please let me know as soon as possible so that I can determine whether or not it will be necessary for me to request a meeting with Judge Reed.

With best regards,

Sincerely yours,

/s/ FRANK H. ABBOTT

FRANK H. ABBOTT
For SCHNADER, HARRISON, SEGAL & LEWIS

Exhibit 40

SCHNADER, HARRISON, SEGAL & LEWIS

(Letterhead)

September 25, 1975

TO: HOSPITALS REPRESENTED BY DVHC IN CURRENT BLUE CROSS NEGOTIATIONS

1. As a result of the hospitals submitting fiscal 76 budgets to Blue Cross, certain hospitals are receiving a Blue Cross form letter from Doctor Baker which includes a form entitled "Detail of Adjustments". This information is allegedly needed to determine whether the imposition of the Medical School "cost ceiling" will affect your institution.

The letter invites your comments to two suggested approaches: (1) meet and negotiate a "cost ceiling" with respect to the 1976 budget or (2) Blue Cross will apply the Medical School "cost ceiling" to determine the fiscal 1976 interim per diem rate for your hospital.

Blue Cross' attorney has assured me that the sole purpose in obtaining the information is to establish the interim per diem rate and will have no effect on final settlement. On this basis, you should:

(a) Provide the requested information, and

(b) Not meet with Blue Cross to negotiate a "cost ceiling".

2. Hospitals are also receiving a memo from Mr. Gannon of Blue Cross containing instructions and two sets of Revised Blue Cross Cost Report forms for the submission of your June 30, 1975 Blue Cross Cost Reports, plus a form entitled "Detail of Flow-Through Costs FYE 6/30/75." Blue Cross' attorney has assured me that the only purpose for requesting the flow-through information

Exhibit 40

is to set the 75 flow-through information against the 1976 flow-through information; that they intend to fully abide by the Crozer settlement and pay the "full reasonable costs" for 1975 and that Blue Cross is not seeking the information to apply any "ceiling" to the final settlement for fiscal 1975. Accordingly, we recommend you provide the flow-through information requested.

3. Some hospitals are receiving requests from former patients for a refund of money paid by the patient. Since Blue Cross is deducting everything they have paid to all subscribers whether the subscriber has paid the hospital or not, we recommend you notify anyone making such a request that until the Courts resolve the Constitutionality of Act 94, there is no way to determine what refund if any they are entitled to and that as soon as it can determined they will receive it.

Sincerely yours,

/s/ FRANK H. ABBOTT

FRANK H. ABBOTT
For SCHNADER, HARRISON, SEGAL & LEWIS

BLUE CROSS OF GREATER PHILADELPHIA
1333 Chestnut Street, Philadelphia, Pennsylvania 19107

(Letterhead)

October 6, 1975

TO: The Chief Executive Officer of Each
DVHC Represented Hospital

By my letter dated September 23, 1975, you were advised that, as part of the implementation of Public Act No. 94, we are reviewing fiscal 1976 budgets in order to

Exhibit 40

establish interim rates as soon as possible. In that regard, we invited your comments as to a methodology which would avoid the freezing of interim rates, as contemplated by the 1972 Amendment to the 1971 Hospital Agreement.

Subsequent to the delivery of the September 23 letter, our attorneys were requested by Frank H. Abbott, Esq., counsel to the Delaware Valley Hospital Council, to advise as to whether or not any ceilings would be established on final settlements. In short answer, the letter of September 23, 1975 dealt only with the establishment of interim rates and does not affect the final settlement of any fiscal year.

With regard to final settlement, you are aware, a formal settlement was entered into by us and the DVHC represented hospitals as a result of the litigation instituted in the Court of Common Pleas of Delaware County known as, *Crozer-Chester, et al.* v. *Blue Cross of Greater Philadelphia,* No. 9799 of 1974. In that Agreement, specific provision was made in paragraph 4 for settlements at the end of the run out period referred to in that document. In other words, final settlement will involve payments to you for "full reasonable costs" which, of course, as determined by the circumstances, might be greater or less than the interim rates. It is, and always has been, our intention to fully conform with that Agreement and Public Act No. 94 with regard to the fiscal years affected by the Agreement and legislation.

I trust the foregoing clarifies the questions raised by your counsel. However, if you have any inquiries with regard to your individual situation, please feel free to contact this office.

Very truly yours,

/s/ Howard W. Baker

Howard W. Baker, M.D.
Vice President

Exhibit 41

BASIC ADVANCES

Abington	$ 261,652.00
All Saints	5,231.00
Bryn Mawr	227,000.00
Bryn Mawr Rush	6,800.00
Chestnut Hill	115,633.00
Delaware County	153,960.00
Doylestown	37,301.00
Episcopal	140,000.00
Frankford	114,810.00
Germantown	122,033.00
Holy Redeemer	203,530.00
Jeanes	101,260.00
J.F.K.	65,000.00
Lankenau	327,457.00
Magee	15,937.00
Memorial of Roxborough	160,654.00
Methodist	145,484.00
Mercy Catholic	314,002.00
Montgomery	92,896.00
Nazareth	192,757,00
Northeastern	122,414.00
Paoli	64,345.00
Phoenixville	51,942.00
Presbyterian	140,985.00
Riddle	132,763.00
St. Christopher's	82,276.00
St. Joseph's	43,004.00
Sacred Heart General	89,732.00
Sacred Heart (Norr.)	95,092.00
Suburban General	59,264.00
Taylor	56,446.00
West Park	83,112.00
Wills Eye	67,177.00
	$3,502,779.00

Exhibit 41

SUPPLEMENTAL ADVANCES

Mercy Catholic Medical Center	$ 314,002.00
St. Christopher's	82,276.00
Total	$3,899,057.00

Exhibit 42

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT

Docket No. R75-9-22

IN THE MATTER OF:

RATE FILING OF BLUE CROSS OF GREATER PHILADELPHIA FOR RATE ADJUSTMENTS OF JULY 31, 1975.

Filing Nos. 2-P-75; 3-P-75; 4-P-75; 5-P-75.

ORDER AND ADJUDICATION

AND NOW, this 16th day of October, 1975, William J. Sheppard, Insurance Commissioner of the Commonwealth of Pennsylvania makes the following Order and Adjudication:

It is appropriate to mention at this time the contract dispute between the Delaware Valley Hospital Council and Blue Cross of Greater Philadelphia. The construction of the contract has been a matter of considerable dispute and discussion among the parties and the Insurance Department. The Department is hopeful that a viable agreement will be reached in the reasonably immediate future which will encompass, among other things, appropriate methods of cost control and utilization review.

Due to the emergency nature of the subject rate request, the rate request will be approved as filed. The Department cautions Blue Cross of Greater Philadelphia, however, to exercise a greater degree of care in the future concerning the timing of their request for rate relief. It is appropriate to note at this time that Blue Cross of Greater Philadelphia requested and received their last rate increase for Non-Group and Non-Credible Group business in 1972; obviously, the three-year interval was too long a delay.

Exhibit 42

CONCLUSIONS OF LAW

1. The Insurance Commissioner has jurisdiction over the parties and the subject matter of this proceeding.

2. Proper notice of this proceeding was given.

3. The proposed filing meets the requirements for approval pursuant to 40 Pa.S. § 6124.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, IT IS ORDERED THAT:

Effective October 15, 1975, Filing Nos. 2-P-75. 3-P-75, 4-P-75 and 5-P-75 are approved for an increase of 35.0%.

/s/ WILLIAM J. SHEPPARD

WILLIAM J. SHEPPARD
Insurance Commissioner

Exhibit 43

LISTING OF HOSPITALS WHICH HAVE EXECUTED THE 1974 AGREEMENT

American Oncologic Hospital
Childrens Hospital
Community Memorial Hospital
Delaware Valley Hospital
Albert Einstein Medical Center
Friends Hospital
Graduate Hospital
Grand View Hospital
Hahnemann Medical College Hospital
Hospital of the Home for the Jewish Aged
Hospital Medical College of Pennsylvania
Hospital Philadelphia College of Osteopathic Medicine (Barth Pavillion)
Hospital University of Pennsylvania
Thomas Jefferson University Hospital
Lower Bucks Hospital
Metropolitan Hospital
Moss Rehabilitation Hospital
North Penn Hospital
Northwestern Institute of Psychiatry
Pennsylvania Hospital
Pennsylvania Institute
Philadelphia Psychiatric Hospital
Pottstown Hospital
Quakertown Hospital
St. Agnes Hospital
St. Luke's & Children's Medical Center
St. Mary—Philadelphia
St. Mary—Langhorne
Temple University Hospital

Exhibit 44

BEFORE THE INSURANCE DEPARTMENT
OF THE
COMMONWEALTH OF PENNSYLVANIA

Public Hearing Regarding
BLUE CROSS
of
GREATER PHILADELPHIA

Wednesday, March 17, 1971
Room 296 City Hall
Philadelphia, Pennsylvania
9:00 a.m.

PRESENT:

For the Pennsylvania Insurance Department:

HERBERT S. DENENBERG, Ph.D., Commissioner
JOHN J. SHEEHY, Director, Bureau of Rates
ROBERT A. MILLER, ESQ., Chief Counsel
RODNEY PYFER, Special Assistant
PAUL HENNING, Staff Actuary

For the Blue Cross of Greater Philadelphia:

THOMAS F. MANLEY, President
BRUCE TAYLOR, Executive Vice President
DONALDSON CRESSWELL, Chairman, Board of Directors
ROBERT H. YOUNG, ESQ., General Counsel
JAMES S. FEIGHT, ESQ., Staff Counsel

COMMISSIONER DENENBERG: Mr. Taylor, would you like to proceed?

Exhibit 44

MR. BRUCE TAYLOR: Yes, sir. Copies of my statement will be available when I am finished.

There is submitted with my testimony a volume containing our emergency interim rate filing, our merit rating adjustments, an explanation of the merit rating adjustments and various other statistical data. I should note at the outset that none of these rate increases apply to the over-65 age group who are eligible for Medicare.

Because you have directed us to keep our presentation brief, I do not plan to review these documents. It should be understood, however, that they are part of this record, that they have been prepared under my direction and supervision, and that I affirm as a part of my evidence the facts which are set forth in them.

By a letter dated February 8, 1971, you directed approximately 54 questions to us and we have prepared answers to them in writing. These are included in a second volume supporting my testimony.

As an aid to your understanding of our rate problem, we have sought to consider the entire hospital care problem in depth and I hope to present an analysis of the more significant aspects of that problem. Our study leads us to propose a number of substantial changes in present procedures. However, each recommendation will involve repercussions throughout the health care field which must be recognized before the recommendations are adopted or implemented.

As Mr. Cresswell has noted, Blue Cross rates are based on two primary factors; namely, the level of hospital costs and the frequency or incidence of benefit usage by subscribers.

In the area of incidence we have established our own review board of doctors to weed out cases of abuse. We have also required hospitals to establish their own medical review boards. We have made changes in the Blue Cross

contract to encourage outpatients' services, particularly in the diagnostic field.

We have established co-pay features to place some financial responsibility for use on the subscribers. We have conducted a continuous education program directed at the medical profession, hospital staffs and subscribers to discourage unnecessary use of hospital services. We believe that our efforts in this area have been singularly successful.

Until 1970 the Plan, partly due to Medicare, had not experienced a rise in incidence of use for over three years and in some categories incidence had actually declined.

In 1970 our incidence has risen, largely as the result of the co-pay preferred contract which we were required to adopt by the Insurance Department. By raising the available days from 30 to 70 and by expanding outpatient service, this contract made available substantially expanded benefits to subscribers and they have used those additional benefits.

The basis for the requested emergency rate relief rests exclusively in this rise in incidence. Were it not for that rise, our projections in 1969 would have proved accurate and we would not be operating in a deficit position at this time. Perhaps this experience highlights the danger of precipitous action by the Insurance Department.

With respect to hospital costs, Blue Cross converted its hospitals to a cost type contract of the variety which has been approved and from time to time urged upon it by the Insurance Department.

Under that contract a uniform cost accounting procedure for determining cost is employed, the procedure being the same for Blue Cross as it is for the Federal Government Medicare payments and State Government Title 19 payments.

The costs which hospitals incur are not paid by Blue Cross until independent auditors have thoroughly examined the hospital's records and satisfied themselves that the costs were in fact incurred, and were related to inpatient care. You should know that the adjustments made through this procedure annually are substantial.

The present cost contract also incorporated incentives designed to encourage hospitals to curb or reduce their cost levels. It is impossible to evaluate the extent to which some of the newer incentives have been effective in producing savings in hospital costs. However, we believe that all steps to verify hospital costs and to encourage voluntary control of hospital costs have been taken.

If the protection of public interest is to be expanded, then it must be through the establishment of specific involuntary controls over the costs which hospitals incur. Before discussing any such changes, however, one fact should be recognized. The overwhelming cause of hospital per diem costs rising in the past five years has been increases in the pay scales of hospital employees.

As we have said on prior occasions, hospital employees were substantially underpaid and much of this increase has been necessary to bring them to a level comparable with other members of our nation's working force. The extent to which hospital employees receive further wage increases beyond the level now existing is a matter for hospital management and labor negotiations.

Blue Cross is not a participant in that collective bargaining operation and has no authority to make itself a party. Moreover, we have no expertise in the wages of hospital employees.

So much for the hospital costs which we cannot control. What are some of the areas where some control over hospital cost may be possible? Hospitals must be paid their costs if they are to survive, and therefore our in-

quiry must concern itself with areas where costs can be controlled so as to reduce them. A number of areas immediately suggest themselves.

First, some means should be established to control the costs which are paid for facilities or programs which are not adequately utilized.

Second, and related to the first, some method must be devised to eliminate excessive beds in this area since they encourage the delivery system to fill them and thus create costs which under more restrictive conditions might be eliminated.

Third, the entire question of employee numbers requires control to insure that each hospital does not have excessive numbers of salaried physicians, interns, residents, nurses, paramedics, and general employees per patient.

Fourth, and related to the third, the entire system of financing medical education requires study and control since many hospital costs, including the costs of residents and interns, are laregly attributable to medical education.

Fifth, the propriety of depreciation allowances as a part of hospital cost needs analysis, particularly the present practice of allowing accelerated depreciation to hospitals which elect such a procedure.

Sixth, the pressure for pre-admission testing, for the efficient use of facilities, for progressive patient care and for alternates to inpatient care needs to be increased so that each hospital is not free to pursue such programs or ignore them at its pleasure.

Seventh, pressures on hospitals to control the average length of stay for standard procedures and to implement more effective utilization review procedures should be increased. Prolonged length of stay is one of the major problems contributing to the excessive hospital costs in this community.

Before discussing the implementation of these various possibilities by Blue Cross, certain general considerations need to be recognized, however.

First, these changes are unlikely to be wrought through voluntary changes in the Blue Cross-hospital contract. Our past experience makes it clear that hospitals simply won't agree to such changes on a voluntary basis. To inflict such terms on hospitals will remove many of them as providers under our contracts. As a result, our subscribers will be restricted to non-member indemnity benefits, a serious burden on them.

Second, Blue Cross regulation of hospital cost raises serious internal problems. Hospitals vary infinitely and general standards applicable to all cannot be fixed fairly. Differences in plant, in the type of cases, type of medical practice and many other factors affect their cost. To consider these multiple factors properly would require a major expansion of the Blue Cross staff.

Moreover, Blue Cross, even with an expanded staff, is not peculiarly fit for this decisional process. It has no expertise in many of these areas. Moreover, as the payor, Blue Cross decisions could be biased by its interest in reducing its own payments.

Third, decisions on most areas of hospital cost control will have profound influence on the entire health care delivery system. To suggest that such decisions should be exclusively in the hands of a single purchaser of health care is clearly foolhardy. Blue Cross personnel can claim no infallability in this field, nor even special training where medical practice or hospital procedures are involved. Obviously, and without false modesty, this role should not be exclusively ours.

Fourth, legal authority is required to produce involuntary changes in the health care system as it exists today. The changes must be made uniformly in all

hospitals and among the entire medical profession; they must be backed by the financial efforts of the community; and they must have the support of the public in their capacity as patients as well as subscribers to Blue Cross.

Such uniformity can only come through governmental supervision based on law, and not the indirect pressure of changing Insurance Commissioners through a variety of Blue Cross entities.

Finally, it must be recognized that Blue Cross is not the only payor in the health care field and whatever it may recommend cannot possibly prevail if Medicare and Medicaid follow other practices. To date neither the State nor the Federal Government has shown any capacity to provide realistic control of hospital costs.

So much for the general principles.

Blue Cross hereby submits the following proposals deemed most worthy of immediate consideration. In the development of these suggestions, we are well aware of the fact that some proposals will require providers of care to sacrifice certain prerogatives which they heretofore have regarded as rights in the name of cost containment for the benefit of the entire community.

One, licensing legislation. We recommend that the Legislature consider the development and adoption of new licensing legislation which would have as its primary objective protection of the public against unwarranted hospital costs.

Elements which should be included in this legislation are:

(a) Prior approval of the Secretary of Health for the creation of or expansion or replacement of any hospital facility.

(b) Prior approval of the Secretary of Health for any new program of hospital patient care services.

This would prevent any expansion of programs or patient care services without an independent review of the community's need.

(c) Periodic re-certification by the Secretary of Health of the public necessity for the continuation of each existing hospital service. This would routinely eliminate any services having abnormally low usage, such as excessive pediatric or obstetrical beds, underutilized special services for open-heart surgery, high-energy radiation, et cetera.

(d) Prior approval of the Secretary of Health of any capital expenditure in excess of $100,000 for capital renovations or improvements to plant or purchase of equipment.

The Secretary of Health in carrying out these responsibilities State-wide could obtain recommendations of a local independent agency such as the Hospital Survey Committee in the Delaware Valley area. Pending such legislation, we are prepared to seek voluntary acceptance in the hospital contract of a licensing procedure to function through the Hospital Survey Committee.

Two, development of public policy regarding the co-mingling of the cost of education or research with patient care.

Philadelphia has six medical schools, more than any other city in this country. Nine of our larger hospitals are controlled by or operated in conjunction with these medical schools. Additionally, these medical schools have educational affiliations with many of the area's larger hospitals.

In all such hospitals, as well as in some non-affiliated hospitals, the cost of graduate medical education of intern and resident physicians is co-mingled with patient care.

Exhibit 44

The direct expense alone related to this educational cost varies from approximately $1 per patient day in non-affiliated hospitals to $10 per day in medical school hospitals. For all of our hospitals it currently amounts to $25 to $30 million annually. Moreover, it has been increasing at an alarming rate.

These costs do not include the increasing indirect expenses attributable to, one, salaried physician directors of medical education necessitated by the numbers of interns and residents; two, the unknown expenses related to medically unnecessary or duplicated tests resulting from these educational programs; three, the additional days of hospital care resulting from medical teaching programs.

The high average length of stay for hospitals with major teaching programs is discussed in our responses to the Insurance Department questions. While these indirect expenses do not lend themselves to precise measurement, it can be conservatively estimated that they are of the same magnitude as the direct expenses, an additional $25 million to $30 million annually.

While it is generally recognized that there is a national shortage of physicians, it is less common knowledge that excluding osteopathic residents, the percentage of medical residents who are foreign citizens has been estimated by informed sources to be in excess of 50 percent. These student physicians are here for educational purposes only and upon completion of their studies, many will return to their native land.

The medical schools of this area have a long and impressive history in education and development of medical technology. In fact, Philadelphia has been called "The World Capitol of Medical Education". But, since the community's rise in the cost of hospital care has been accelerated both by direct and indirect educational costs, the financing of medical education as a tax on the community's hospital bill must be re-examined.

Exhibit 44

We recommend immediate study, either by the Legislature or the existing State Board of Medical Education and Licensure, or both, to promulgate standards for the number of interns and residents, if any, that consumers of hospital care should reasonably be expected to support as a cost of patient care. Such standards of necessity must be accompanied by appropriate regulation which would exclude from hospital cost and patient charges any expense directly or indirectly related to any interns or residents in excess of the approved complement.

A corollary to educational programs are research programs which involve patient care. Such programs are particularly extensive in medical school hospitals and also serve to inflate the cost of hospital care.

While the direct cost of research is not presently recognized as a reimbursable expense, projects which are intertwined with patient care are included in consumer cost rather than being charged back to the sponsors of the research. We recommend that appropriate regulation be developed establishing standards for the control of this expense.

Pending community decision on this issue, we are prepared to press hospitals for standards designed to control the costs to our subscribers which are associated with medical education.

Three, establishment of public control of hospital staffing patterns.

During the past three years, with notably few exceptions, hospitals of the Delaware Valley area on the average have successively increased their personnel complement. This increase has far outstripped any expansion of patient care services. The salaries and wages of these additional employees account for a substantial increase in total payroll expense.

In order that the public may have adequate assurance that these additional employees, as well as future increases, are necessary and represent a justifiable increase in operating expenses, we recommend the consideration of appropriate regulatory legislation. The objective of such legislation would be to require prior approval of the Secretary of Health for any future increase in employees necessitated by expanded patient services, and would also require a re-evaluation of those increases which have taken place since 1967 with an appropriate roll-back of any unwarranted additions. The Secretary could act on the basis of recommendations of a designated independent local agency such as the Hospital Survey Committee, Incorporated.

Obviously such legislation would require regulations which would make adjustments for the discontinuance of any services, decreases in occupancy rate, elimination of non-conforming beds, or other reductions in bed complement, subcontracting of functions or services, et cetera.

It is impossible, at this time, to determine the effect that such a program would have on the community's total hospital bill, but it is apparent that a significant portion of the annual increases in payroll stem from this source.

Pending necessary legislation in this area, we are prepared to urge upon the hospitals every possible analysis of this problem and to work with the Hospital Survey Committee to bring about voluntary control in the area.

Four, public re-evaluation of the acceptance of depreciation as an element of hospital cost.

The voluntary hospital system was established primarily through philanthropic tax-free gifts and government grants. These funds were contributed for the purpose of establishing hospitals which would have the ability of providing necessary care to the sick of the community. To include depreciation in the cost of hospital care is to

place a charge on the sick people for the use of the facilities which were voluntarily established for their care.

It has a further connotation, that irrespective of how future patterns of care may be modified through technological developments or population shifts, the patients currently using the hospitals have a financial responsibility for the replacement of the contributed capital assets regardless of what the future community need may be.

Many hospitals in this area operated for decades without considering depreciation as an element of the cost of patient care. The Commonwealth itself never recognized this aspect of cost in its various programs of financing hospital care for the needy, until the advent of the Medical Assistance Program.

We recommend that the Legislature give consideration to the appropriateness of the acceptance of depreciation as an element of cost for our voluntary hospitals. Such consideration should recognize that in the event the public policy which is established eliminates depreciation, it would be appropriate to include in cost approved non-operating expenditures for renovations and equipment spread over a reasonable period of years and other approved capital charges, such as amortization of capital indebtedness, as prescribed by appropriate regulations.

Since hospitals in this area have become accustomed to defining cost to include depreciation, not only for Blue Cross reimbursement but for reimbursement by the State and Federal Government and paying patients, we believe that if it is found to be an inappropriate element of cost to be borne by the consumer-patients, we question whether its exclusion can ever be achieved without the compulsion of law.

The amounts being added for depreciation to the direct operating expenses of contracting hospitals vary widely from a low of $1.12 per patient day to a high of

$9.81 per patient day. Depreciation alone currently adds more than $26 million to the community's total hospital bill, and this amount is escalating rapidly. Pending definitive state action, we will press for a change in our hospital contract to eliminate depreciation.

Five, elimination of unnecessary substandard hospital beds.

It is an established fact that the average stay in this Metropolitan area is longer than any city in the state and the longest of any Blue Cross Plan in the United States serving more than 1 million subscribers. This can be seen from the following table which shows Philadelphia with an average stay for persons under 65 in 1969 of 8.50, graduated down to a low of 6.11 in the Louisville, Kentucky, Plan, with the average for all such plans being 7.35.

Despite the many programs and incentives which Blue Cross has poineered to shorten the average stay, with relatively few exceptions, they have not accomplished their objectives. It is a well known axiom that whenever hospital beds are available they tend to be used.

Dr. Eli Ginsberg, Professor of Economics at Columbia University, expressed it this way in a recent articles entitled, "Hospital Costs: Sense and Nonsense": "If one remembers Roemer's law that all beds tend to be used, there will not be even any payoff in my opinion for better professional control over admissions and discharges, or any significant gains through incentive reimbursement policies unless and until tight control is exercised over the total bed complement."

We do not believe that the excessive length of stay in this area can be effectively reduced until tight control over the total bed complement is achieved.

It is also an established fact that many of the hospital beds in the Philadelphia area do not meet the fire

and other safety standards of the Office of Medical Services and Facilities of the Commonwealth and have been classified by that agency as "Non-Conforming Beds". Yet hospitals have been permitted to continue to use these beds for acute care inpatients and this has helped to continue patterns of excessive hospitalization.

If physicians and hospitals generally were obliged to fully implement many of the known cost containment techniques, such as pre-admission testing, establishment of short procedure units, hospital-based home care programs, progressive patient care, planned patient discharge, extension of the hospital work week, use of outpatient facilities as an alternative for inpatient stay, improved occupancy ratio, et cetera, the present bed complement in this area could be reduced, without adversely affecting the availability of facilities for necessary care.

We believe that the State Office of Medical Services and Facilities through close consultation with the Hospital Survey Committee could achieve a reduction in bed complement of as much as ten percent to twenty percent initially. Such a reduction would not only give patients greater protection against the known hazards of continued use of some non-conforming beds, but would also substantially reduce the community total hospital bill through a shortening of the average length of stay coupled with a more effective use of the community's hospital facilities.

We further believe that some of the beds withdrawn from acute care could through renovation be converted to extended care or custodial care facilities, the creation of which would further reduce the average length of hospital stay by providing suitable alternate facilities for the early transfer of patients when the acute phase of their illness has been met. A reduction in the total bed complement of ten to twenty percent would reduce the total hospital bill for this community by $30 million to $45 million annually.

Exhibit 44

We plan to press for a reduction of bed complement through our hospital contract pending effective state action.

Finally, in more general areas, we plan to pursue the extension of limits on the length of hospital stay in our subscriber contracts for standard surgical procedures and to press hospitals to fix standards in these areas. We also plan to exert additional pressure on hospitals to improve the performance of their utilization review committees, to establish pre-admission testing, and to avail themselves of efficiency studies.

In conclusion, the areas for study which we have suggested here are directed primarily toward fundamental changes in our health care delivery system. These suggestions have the potential for reducing this community total hospital bill by $50 million to $100 million annually. They would for years overcome the annual increases in hospital costs which cannot be controlled. Blue Cross share in this saving would be on the order of 30 percent.

In conclusion, we acknowledge that there are problems in our system of delivery of health care. To my knowledge, no other service in our community is delivered under a system in which the customer's health determines when he needs service; a second party, the physician, determines how much service he needs; a third party, the hospital, provides the service up to the quantities and for the length of time determined by the physician. The hospital is then paid whatever its costs were for the service by a fourth party, Blue Cross, and that fourth party seeks to collect from the fifth group, the subscribers.

Since the subscribers are obviously not all patients, it is clear that the economic circle is never closed. Responsibility for the costs incurred is avoided by each of the groups, except the last. Moreover, none of the parties has any real control over the previous party whose decisions caused his activity.

Exhibit 44

We have come to recognize that in attacking the flaws in this type of system there is no panacea which will guarantee solution. However, means for establishing responsibility for hospital care costs all along the line must be developed. Blue Cross now re-states its continued dedication to its subscribers' interest. The fundamental purpose of Blue Cross in Philadelphia is, and always has been, to provide its subscribers a viable method of financing their hospitalization needs.

In this role it serves as a bridge between its nearly 2,400,000 subscribers and those 890,000 occasions in 1970 on which it provided benefits to those subscribers. If the underpinning of this Blue Cross bridge is further impaired through improvident restriction on its finances, its ability to serve both the consumers who require hospital care as well as the consumers who finance that care will have been destroyed, and both consumer groups will be denied this facility for prepaying their hospitalization needs.

COMMISSIONER DENENBERG: Thank you very much, Mr. Taylor.

MR. TAYLOR: Mr. Commissioner, I have certain charts here which I would like to present at this time for the benefit of the Insurance Department Staff and the public who are assembled here.

COMMISSIONER DENENBERG: Fine.

(The charts were brought forward and set up on an easel.)

MR. TAYLOR: This particular chart illustrates the dollar change over a long period of time which has taken place in Blue Cross premiums, which is the bottom line here, from 1947 through 1970, which shows a rise in premiums here through the present level which is about $25 per month for a family contract.

The various other lines indicate the average monthly wages for various types of workers as are illustrated there, the bottom being the wholesale and retail industry, service industry, finance, manufacturing, mining, transportation, and at the top construction.

But the chart largely illustrates that not only while Blue Cross has been affected by inflation over a long period of time, that wages have likewise been affected but also have gone up at a much faster rate.

COMMISSIONER DENENBERG: To look at that chart it looks like you're almost giving it away, the way it is set up.

MR. MILLER: Where would hospital costs fit on that chart, Mr. Taylor?

MR. TAYLOR: The hospital costs, I think, really are reflected in the Blue Cross premiums.

MR. MILLER: Would they have climbed at a much steeper rate than the premiums over that period of time?

MR. TAYLOR: I think the rate of increase is a steeper rate, but the dollars of hospital cost have not. The premiums have been adequate to cover the hospital costs.

COMMISSIONER DENENBERG: Incidentally, are these in your presentation?

MR. TAYLOR: No, they are not, but copies will be made available to the Department.

COMMISSIONER DENENBERG: Okay. Proceed.

MR. TAYLOR: This chart deals with three basic subjects. The blue bars on the chart indicate the number of claims which Blue Cross paid, and the green area indicates the dollar value of those claims.

If you notice, looking only at 1969 and 1970, in 1969 the financial value of the claims or the dollar value paid increases from $137 million in 1969 to $172 million in 1970.

You also notice that the number of claims or the occasions on which the subscribers benefitted from Blue Cross increased from 736,000 to 890,000, reflecting largely the increase in scope of coverage available to subscribers through the co-pay preferred contract.

It is also interesting on looking at the benefits which subscribers received from another direction, this chart illustrates the numbers of cases which exceeded $1,500 in benefits. You will notice that in 1967 the number of subscribers receiving hospital care benefits from Blue Cross in excess of $1,500 were 8,438. In 1970 this number had expanded to 25,708.

This illustrates the importance of Blue Cross benefits to many of our subscribers and also shows the relationship here of how small Blue Cross premiums are to how large the benefit payments may be.

MR. MILLER: How does that compare with the general increase in subscribers over that same period of time, Mr. Taylor?

MR. TAYLOR: The general increase in subscribers between 1967 and 1970, while it has increased slightly, has been relatively stable. A very small amount of the increase shown on here would be attributable to additional subscribers.

Finally, Mr. Commissioner, and perhaps most significant of all, I would like to present for you this chart which indicates what our actual reserves have been and what our projected reserve position is.

This information is included in the emergency rate interim filing.

It shows that the reserves in 1967 were $20 million. It shows that because the Plan has consistently operated since that time on an inadequate rate base, that the constant demand on reserves reduced it to a $2 million level at the end of January, and that our projections here on a

monthly basis show that by the end of July the minus amount or negative amount of reserves unless the interim rate adjustment is granted will be close to $10 million.

Thank you.

COMMISSIONER DENENBERG: May we have copies of those charts at this time for the record?

MR. TAYLOR: Yes.